IMPACT OF CRACK COCAINE ON THE CHILD WELFARE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

APRIL 3, 1990

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IMPACT OF CRACK COCAINE ON THE CHILD WELFARE SYSTEM

TUESDAY, APRIL 3, 1990

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 11:15 a.m., in the auditorium, Children's Hospital, 111 Michigan Avenue Northwest, Washington, D.C., Hon. Thomas J. Downey (acting chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, MARCH 14, 1990

PR #19
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE THOMAS J. DOWNEY (D., N.Y.), ACTING CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES SITE VISITS AND FIELD HEARING IN WASHINGTON, D.C., ON THE IMPACT OF CRACK COCAINE ON THE CHILD WELFARE SYSTEM

The Honorable Thomas J. Downey (D., N.Y.), Acting Chairman, Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, today announced that on Tuesday, April 3, 1990, the Subcommittee will travel to two local hospitals for a site visit and field hearing on crack cocaine and its impact on the child welfare system.

The Members' only site visit will begin at D.C. General Hospital where the Members will tour the intensive care and transitional nurseries, and the "boarder baby" ward. Members will next proceed to Children's Hospital to visit its nationally recognized Division of Child Protection. The hearing, which is open to the public, will begin at 11:00 a.m. in the Children's Hospital Auditorium, 111 Michigan Avenue, N.W., Washington, D.C.

In announcing the hearing, Chairman Downey said: "Experts say the drug problem today has a new face -- a baby's. The physical and mental well-being of at least 100,000 babies, as well as countless thousands of older children, will be affected by cocaine this year. Mounting numbers of crack-exposed children are appearing in our nation's hospitals, child protection and child welfare systems, and foster care agencies. This field hearing will give us a unique, first-hand look at how the maternal use of drugs, especially crack, affects children, parents and, in turn, our child welfare programs. We will also discuss the hard questions that arise as society moves to sanction the drug-abusing mother."

Oral testimony before the Subcommittee will be limited to invited witnesses only. The witnesses will focus their testimony on what is known about the immediate and long-term developmental and behavioral consequences for the child of prenatal exposure to crack cocaine, the diversity of outcomes for children exposed to the drug, the profile of the crack-using mother and prospects for her recovery through treatment, the extent to which the drug is a factor in the growing child protection and foster care caseloads, and the legal and other issues regarding prosecution and sanctions.

All witnesses scheduled to appear are required to bring 100 copies of their prepared statements to the hearing at the Children's Hospital Auditorium, at least one-half hour in advance of their scheduled appearance.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Thursday, April 19, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public, they may deliver 100 additional copies for this purpose to the hearing site on the morning of the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Acting Chairman DOWNEY. The subcommittee will come to order.

First of all, let me thank the people who have spent their time and energy today to show us some of the children here at Children's Hospital and to those of you who have come from D.C. General.

There is a poet who once said that each child that is born is an indication of God's faith in humanity. I think we have seen that thesis tested today, not by the people who care about children, but by some of the parents and some of the conditions that children live in.

We are—I think I can speak for my colleagues—deeply moved by what we have seen and profoundly disturbed. And we will take what we learned here today and apply it usefully, we hope in the law and our resources in the future.

[The prepared statement of Mr. Downey follows:]

OPENING STATEMENT OF HON. THOMAS J. DOWNEY, ACTING CHAIRMAN

A growing number of experts say the drug problem today has a new face—a baby's. Two Federal agencies estimate that 100,000 babies were born with cocaine in their bodies last year. While the majority of these babies exhibit no outward symptoms, the physical and mental well-being of many—not to mention their older brothers and sisters—is threatened. We know of this newest group of innocent victims by their mounting numbers in our nation's hospitals and our child protection and foster care caseloads. We see them as "premies" in our nurseries, as boarder babies, and among the abused and neglected children brought to our hospitals and social service agencies. Unfortunately, we know little about their future prospects, yet many families are afraid to care for or adopt them.

I hope that this hearing will help us understand the extent of damage wrought by drugs—in particular crack—against children and their families. Dr. Barry Zuckerman, Director, Division of Developmental and Behavioral Pediatrics at Boston City Hospital, will discuss what we know and don't know about the prevalence and consequences of prenatal exposure to cocaine.

Both he and Ms. Margie Clay, Program Coordinator of the DEMAND Treatment Program, Minneapolis, Minnesota, will teach us about crack-addicted mothers and the issues that arise in their treatment.

Next, we will learn how cocaine use is affecting the caseloads and operations of a particular child welfare agency. Ms. Ina Redd Denton, who oversees the Cook County Operations of the Illinois Department of Children and Family Services, will discuss what services are available to drug-involved families; the issues that arise as crack children enter the child protection, foster care and adoption systems; and whether current Federal child welfare laws are adequate to address this drug problem.

Finally, Robert Horowitz, Assistant Staff Director of the Center on Children and the Law, at the American Bar Association, will brief us on current State efforts to punish drug-abusing women, and the implications of sanctions for the mother and her children.

Before we begin, I would like to thank each of the witnesses for traveling to be with us today. I would also like to thank the staff and officials at Children's National Medical Center for their assistance in arranging this hearing, and for granting us the use of their auditorium.

Acting Chairman DOWNEY. Mr. Shaw, did you want to say anything?

Mr. SHAW. I have just a short prepared statement which I would like to insert into the record.

[The opening statement of Mr. Shaw follows:]

OPENING STATEMENT OF HON. E. CLAY SHAW, JR.

Once again, Mr. Downey, I want to compliment you for holding these important hearings. Our nation is full of talk about drugs, but few people are fortunate enough

to be in a position to do anything about this national scourge. The Ways and Means Committee, however, controls many of the programs that can provide help to drug-addicted parents and their children.

Our Members are deeply interested in this problem and will closely follow these hearings over the next three days to determine whether new legislation is needed. As you know, Mrs. Johnson intends to introduce legislation later this year; we are hopeful that this legislation will enjoy bipartisan sponsorship.

Before we can craft good legislation, we need basic information about drug addiction and its effect on babies and young children. Over the years I have come to regard what I read in the newspapers with some skepticism. On the fundamental issues of drug addiction I have even more skepticism about what I read in the newspapers.

Today, thanks to the superb work of Mr. Downey and the majority staff, we have the opportunity to get direct answers to our questions about the prevalence of drug abuse among pregnant women and about the impact of drug abuse on children.

All of us on the minority side want to express our gratitude to the fine witnesses who have agreed to take time from their busy schedules to help instruct us on this vital topic.

Mr. SHAW. And, Tom, I would like to compliment you as acting chairman of the subcommittee for having this hearing today. As you and I have spoken during the day, we perhaps might expand this type of hearing to other areas around the country.

We have learned this morning that at D.C. hospitals, some 20 percent of the babies born have mothers who have used an illegal substance—and that was only by their own admission. So, perhaps that statistic might even be much worse. It was estimated by one of the doctors that it might be even as high as 35 percent.

We are seeing the problems cropping up now in the schools. It is not just a D.C. problem. We have it all over Florida, New York, Pennsylvania, and every other State in the Union where cocaine-addicted babies now are getting into the school rooms. And we are finding that 10 percent of the classes now in the lowest grades are babies that were born to a mother who did abuse illegal substances. And the behavioral problems—we do not even know the full extent of that. We have also learned that not only the human loss, but the financial loss that is brought about by these children is mind boggling.

I would say that it is the worst indictment of our society, that we are allowing this to go on. And it is growing. If you say that 10 percent of the children coming into the first grade or kindergarten were drug-addicted at birth, then you say that 20 percent of the babies now born at D.C. General Hospital are addicted you know it does not take any higher mathematics to know that the problem is getting worse at a very alarming and very scary rate.

So, I do not know where the answers are, but we certainly have identified a lot of the problems this morning. I look forward to this hearing.

Acting Chairman DOWNEY. Mr. Coyne.

Mr. COYNE. I have no opening statement.

Acting Chairman DOWNEY. Dr. Zuckerman has to leave us at 12. Let's begin with him. Dr. Zuckerman is the director of the division of developmental and behavioral pediatrics at Boston City Hospital. He is going to discuss with us what we know and what we do not know about the prevalence and the consequences of prenatal exposure to cocaine. Dr. Zuckerman.

STATEMENT OF BARRY ZUCKERMAN, M.D., DIRECTOR, DIVISION OF DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, BOSTON CITY HOSPITAL; PROFESSOR OF PEDIATRICS, BOSTON UNIVERSITY SCHOOL OF MEDICINE; AND MEMBER, NATIONAL COMMISSION ON CHILDREN

Dr. ZUCKERMAN. Thank you. Good morning, Mr. Chairman and the subcommittee members. Thank you for inviting me.

The goal of my testimony is to separate fact from sensationalism, to describe what is known from what is suspected, and to suggest strategies to help pregnant and parenting women reduce drug use and improve the health and well-being of infants and mothers.

I will address four aspects of this problem. The first is the prevalence of cocaine use during pregnancy. Estimates primarily from urban hospitals show 5 to 20 percent of infants are exposed to cocaine prenatally. At this point, we do not know how prenatal cocaine use varies by geographic regions or by social class. It is frequently cited that as many as 375,000 newborns per year are exposed to illegal drugs. From the point of view of the fetus, the biologic impact of a substance is more important than its legal status. In fact, cigarette smoking prenatally is more harmful than marijuana.

Pregnancies of women who use cocaine are at risk not only because of cocaine use, but because of poor nutrition, sexually transmitted diseases, use of cigarettes, marijuana, alcohol and lack of prenatal care. Therefore, infants born to mothers who use cocaine have a high likelihood of suffering problems at birth such as low birth weight, prematurity, small head size, neurobehavioral dysfunction, as well as rare but catastrophic events, such as stroke.

Part of the value of prenatal care is to help women decrease or stop using drugs. If women stop using cocaine before the third trimester, the risks of low birth weight, which often require expensive neonatal intensive care, are greatly reduced. Approximately one-third to one-half of the women receiving prenatal care stop using cocaine before the third trimester. Therefore, threats of prosecution may be counterproductive because the fear of losing custody of their children will drive women away from prenatal care and thereby increasing the risk of low birth weight and increasing the costs.

A third aspect of the problem is what are these babies like when they get older. In a word, we do not know. I hear the same reports and concerns that you do, and at this point we do not really have any data to know for sure. But the concern is very high.

It is important to realize children's development depends on an interplay of biological and social factors. The outcome among children exposed to cocaine will most likely vary due to a combination of the amount and timing of exposure to cocaine, the presence of other drugs and other risk factors before birth, as well as stressful early life experiences such as poor caretaking due to addicted parents and/or multiple caretakers and multiple foster placements. Anecdotal reports support the variability and outcome with descriptions ranging from children having problems with emotions, behavior and learning to other children being normal.

I am, however, very concerned about the stereotyping of cocaine-exposed infants as disabled and damaged. This has already resulted in one adoption agency declaring cocaine infants unadoptable.

Research on opiate-exposed infants, as well as premature infants, show that the most critical determinant of the child's outcome is the quality of the child's postnatal environment. Until proven otherwise, I would like to believe that cocaine-exposed babies will have the same potential for recovery and good development.

Lastly, I have concerns about stereotyping mothers. In my experience, women who use cocaine are as different from each other as women who do not use drugs. They differ in the amount of cocaine they use and their interest and ability to care for their children. In one study, half of the cocaine users used cocaine weekly, while a third used it less than once a month.

As a pediatrician, pregnancy and the birth of a baby provides me with a special window of opportunity to engage women at a time when they are especially receptive to accept help and improve their and their infants' lives.

We have developed a small, special pilot program for 14 women and their infants at Boston City Hospital involving pediatric care, child development, drug treatment and family planning at one site in the pediatric primary care clinic. This is a 2-for-1 program in that we provide care for both the mother and the infant. What has impressed us is that 12 of the 14 women appear to be benefiting from this comprehensive, but relatively nonrestrictive program. The important components of this program are one-stop shopping—that is, key services are located in one place—and a therapeutic alliance focused on drug treatment. The incremental cost is minimal. For the babies who are between 4 and 6 months of age, all but one appears to be developing normally. Some of these women will need more restrictive treatment such as residential placement. However, our program keeps women in the system, provides them with needed services and allows us to get to know them better over time in order to identify their drug treatment needs in the long run.

I believe most cocaine-using women will benefit from good, comprehensive and accessible services because they care about their infants. Foster homes need to be identified and supported for those infants whose mothers or families cannot adequately care for them. Decisions regarding the child's caretaking and future need to be made in the best interest of the child. A punitive approach, on the other hand, will cost more and damage children.

I want to briefly tell you the story of one of our patients. P.B. is a 24-year-old, single, unemployed Hispanic woman who is the second oldest of seven children. Three siblings are addicted to cocaine, and another tried to commit suicide. During her childhood, Ms. B's mother sold drugs and was an alcohol, heroin, cocaine and marijuana user. She was physically abused by her stepfather and sexually abused by uncles.

At 14 she left home and went to live with her boyfriend with whom she had a child at age 17. He also used drugs and physically abused her during the next 4 years. She moved back and forth between her abusive mother and her abusive boyfriend. In 1987 a brother showed her how to smoke crack, and she quickly started using it daily. She discovered that when she was high she did not

fight with her mother and therefore her mother wouldn't beat her up.

During her present pregnancy, she smoked crack daily for the first 7 months and drank about three beers per day. Four months ago, her daughter was born full term without complications of labor or delivery and weighed 6 pounds 13 ounces, but was poorly responsive. Ms. B. has reported two relapses of using cocaine, one at 2 weeks and another at 6 weeks postpartum. The baby has received all of her immunizations demonstrating her mother's interest and ability in insuring her health. The child is delightful and thriving. Her social, emotional and cognitive development appear to be normal at this point in time.

I think most of us who work with women this way find the first 6 months in some ways the easiest because mothers really focus in on their baby, but we are concerned that as the infant becomes less dependent, the mothers are going to have a difficult time coping. But at this point in time, the mother has responded well to her child and has participated in caring for her child.

Her story raises the following question in mind, though. At what age did we stop feeling sorry for her as a victim and become angry at her as the victimizer? If we were as willing to spend as much money when she was a child, as some people would now have us spend in order to put her in jail, we might have prevented this continuing cycle of pain and destruction.

I would like to conclude by placing the present problem in a larger context. I have been a pediatrician in inner city Boston for the past 18 years. Children in poverty suffer disproportionately high rates of problems such as low birth weight, malnutrition, anemia, lead poisoning and mental health problems. These problems impair children's ability to learn. They struggle in school and become frustrated and see themselves as inadequate and failures. These problems preceded crack. Boarder babies are not new at Boston City Hospital. Crack is a relatively new problem that will add to and may even be in part a consequence of these other problems.

In response to the problems children have suffered by falling through gaping holes in the safety net, society has developed categorical programs. This band aid approach, while well-intentioned, divides children and their families into pieces called health, welfare, nutrition, child development, education, social services.

Drug treatment programs for mothers and their infants need to be developed, but have to be part of a larger, coordinated and comprehensive system that emphasizes prevention and treatment for the whole child and family. Special programs for drug-exposed infants and their mothers will not help unless they are part of an effort that takes an early, continuous and comprehensive approach again to the whole child and family. Thus all—not 50 percent—of eligible mothers and children should receive needed nutritional supplementations through WIC and all—not 20 percent—of eligible children should receive Head Start. The onslaught of crack cocaine has brought a new focus to these enduring problems. Our Nation's future depends on our commitment to address them now. Thank you. I will be happy to answer any questions you may have.

[The prepared statement of Dr. Zuckerman follows:]

TESTIMONY of BARRY ZUCKERMAN, M.D.

AS AN EXPERT IN THE FIELD OF PRENATAL COCAINE USE

Good Morning Mr. Chairman and Subcommittee Members: Thank you for inviting me. My name is Barry Zuckerman. I am Professor of Pediatrics at the Boston University School of Medicine and Boston City Hospital. I am also a member of the National Commission on Children. The goal of my testimony is to separate fact from sensationalism, to describe what is known from what is suspected and to suggest effective strategies to help pregnant and parenting women reduce drug use and improve the health and well being of infants and mothers.

I will address four aspects of this problem. The first is the prevalence of cocaine use during pregnancy. At Boston City Hospital we conducted the most systematic study to date on cocaine use during pregnancy. Between 1984 and the end of 1987, 18% of women receiving prenatal care used cocaine during pregnancy. Less systematic surveys at other hospitals, mostly in urban settings, demonstrate lower rates of exposure (5-15%). However, these estimates may be somewhat underestimated because urine assessments conducted at delivery will miss many women who used cocaine earlier in pregnancy because urines for cocaine will only stay positive three to five days after it is used. We do not know how prenatal cocaine use varies by geographic regions or by social class.

It is frequently cited that as many as 375,000 newborns per year are exposed to illegal drugs. This estimate includes marijuana. From the point of view of the fetus, the biological impact of a substance is more important than its legal status. In face, cigarette smoking prenatally is more harmful to the fetus than marijuana.

The second aspect of the problem is the impact of cocaine use on the fetus. Infants exposed to cocaine during pregnancy have difficulty becoming alert and responding to their mothers. This behavior could represent withdrawal from cocaine or it could also be due to chemicals in the brain altered by cocaine, structural defects in the brain secondary to cocaine or to acute effect of cocaine itself. Since addiction has not been substantiated, infants should be referred to as cocaine or crack exposed rather than "crack addicted".

Pregnancies of women who use cocaine are at risk not only because of cocaine use but because of poor nutrition, sexually transmitted diseases, use of cigarettes, marijuana and alcohol and lack of prenatal care. Therefore, infants born to mothers who use cocaine have a high likelihood of suffering problems at birth such as low birthweight, prematurity, small head size, neurobehavioral dysfunction as well as rare but catastrophic problems such as stroke. Cocaine is one of many important factors that contribute to these outcomes. When prenatal care is comprehensive, it addresses these risks by providing medical services, nutritional supplementation (WIC), and social services interventions.

Part of the value of prenatal care is to help women decrease or stop using drugs. If women stop using cocaine before the third trimester, the risks of low birthweight which often require expensive neonatal intensive care are greatly reduced. Approximately one third to one half of women receiving prenatal care stop using cocaine before the third trimester, 67% stop before delivery. Therefore, threats of prosecution may be counter-productive because the fear of losing custody of their children will drive women away from prenatal care thereby increasing the risk of having a low birthweight infant.

A third aspect of the problem is what are these babies like when they get older. We don't know. Children's development depends on an interplay of biological and social factors. The outcome among children exposed to cocaine will most likely vary due to a combination of the amount and timing of exposure to cocaine and the presence of other drugs and risk factors before birth as well as stressful early life experiences due to poor caretaking by an addicted parent and/or multiple caretakers. Anecdotal reports support the variability in outcome with descriptions ranging from problems with emotions, behavior and learning, to being normal. I am, however, very concerned about the stereotyping of cocaine exposed infants as disabled and damaged. This has already resulted in one adoption agency declaring cocaine infants unadoptable.

Research on opiate exposed infants as well as premature infants show that the most critical determinant of the child's later outcome is the quality of the child's post natal environment. Until proven otherwise, I would like to believe that cocaine exposed babies will also have the same potential for recovery and

good development if they are also provided with good caretaking, pediatric health care, early intervention and other needed services.

Lastly, I have concerns about stereotyping mothers. In my experience, women who use cocaine are as different from each other as are women who do not use drugs. For example, they differ in the amount of cocaine used, their interest and ability to care for their infant, the availability of nondrug family members who help them care for their child. In one study, half of the cocaine users used cocaine weekly while a third used it less than once a month.

As a pediatrician, pregnancy and the birth of a baby provides me with a special window of opportunity to engage women at a time when they are especially receptive to accept help to improve both their and their infant's lives.

We have developed a small, special pilot program for 14 women and their infants at Boston City Hospital involving pediatric care, drug treatment, child development services, and family planning at one site in the pediatric primary care clinic. This is a two for one program in that we provide care for both the mother and her infant. What has impressed us is that 12 of the 14 women appear to be benefiting from this comprehensive but relatively nonrestrictive program. The important components of this program are one-stop shopping (key services are located in one place), and a therapeutic alliance focused on drug treatment. The incremental cost is minimal. For the babies who are between four and six months of age, all but one appears to be developing normally. Some of these women will need more restrictive treatment such as residential placement. However, our program keeps women in the system, provides them with needed services and allows us to get to know them over time in order to identify their drug treatment needs. Without this program women receive services if they can get it (87% of drug treatment programs in New York City excluded pregnant medicaid women) depending on what door they knock on.

I believe most cocaine using women will benefit from good comprehensive and accessable services because they care about their infant. Foster homes need to be identified and supported for those infants whose mothers or families cannot adequately care for them. Decisions regarding the child's caretaking and future need to be made in the best interest of the child. A punative approach, on the other hand, will cost more and damage children.

I would like to conclude by placing the present problem in a larger context. I have been a pediatrician in inner city Boston for the past 18 years. Children in poverty suffer disproportionately higher rates of problems such as low birthweight, malnutrition, anemia, lead poisoning and mental health problems. These problems impair children's ability to learn. They struggle in school and become frustrated and see themselves as inadequate and failures. These problems preceded crack. Crack is a relatively new problem that will add to and may even be in part a consequence of these other problems.

In response to the problems children have suffered by falling through gaping holes in the safety net, society has developed categorical programs. This bandaid approach, while well intentioned, divides children and their families into bureaucratic pieces called health, welfare, nutrition, education, child development, social service, etc. Drug treatment programs for mothers and their infants need to be developed but have to be part of a larger coordinated and comprehensive system that emphasizes prevention and treatment for the whole child and family. Special programs for drug exposed infants and their mothers will not help unless they are part of an effort that takes an early, continuous and comprehensive approach to the whole child and family. Thus all, not 50% of eligible mothers and children should receive needed nutritional supplementation through WIC and all, not 20% of eligible children should receive Head Start. We know how to do better and we can do better. The onslaught of crack/cocaine has brought a new focus to these enduring problems. Our nation's depends on our commitment to address these problems now.

Acting Chairman DOWNEY. Thank you, Dr. Zuckerman.

What I propose is that the subcommittee inquire of Dr. Zuckerman briefly and then we will hear from our other three witnesses.

Dr. Zuckerman, you have dispelled some myths here. It is popular to just talk about what crack and cocaine does to babies and ignore the fact that cigarettes and alcohol are almost as damaging in some instances.

What do you do in Boston to identify women potentially at risk? And would you suggest to us with the resources that we have available that not only do we coordinate services, but possibly look at people at risk as maybe our major focus in attempting to deal with this problem?

Dr. ZUCKERMAN. I think until shown otherwise, we are talking about families in poverty.

And we are struggling in Boston about how to identify women at risk.

These programs I mentioned—have identified women, at the time of birth because of a variety of risk factors, which leads us to get urine toxicologies on babies. I do not believe however, the high tech of urine identification is the answer. Rather the answer lies in service providers having relationships with families and through those relationships, one understands a family's needs and problems, and that includes drug use.

So, really what we are talking about are family support programs involving relationship at the start of pregnancy. Relationships are expensive. I do not believe there is any shortcut in providing services for at-risk people. The key is relationship between a service provider and parent.

In some ways, without rediscovering the wheel, the old settlement house provides a very important mechanism for families to develop and thrive because there's a place where—we talk about one-stop shopping now, but that is what a settlement house was. People who worked there were working for the people and not for agencies, and through that, needs were identified and problems solved.

So, again, we do not have the answer of complete identification, but I think we need systems where people have relationships and they are welcomed to our system. We tell people to go to prenatal care. However, they have to stand in line for hours to see doctors and wait in waiting rooms for a long period of time. Their lack of respect does not encourage anyone into coming back. We are not giving the correct messages.

Acting Chairman DOWNEY. You mentioned two things, that we finance Head Start adequately, fully, and that we finance WIC. Are there any other suggestions that you would make to the members of the subcommittee as to what you would like to see us do?

Dr. ZUCKERMAN. Well, I think the notion, again using that phrase, one-stop shopping, which came out of the infant mortality report, is critical. I think that by colocating services, we can actually cut administrative costs and provide more services let alone cut down a lot of the barriers that are involved in multiple service.

I think in some ways we know some of the things to do. We know about drug treatment. We know about nutrition. We know about Head Start. We know about health care. I think the challenge for

the 1990's is implementation and how we organize those services at a local level and provide local people enough flexibility to fund according to the needs of the community.

Acting Chairman DOWNEY. Mr. Shaw.

Mr. SHAW. Dr. Zuckerman, you spoke of birth weight during the third trimester. I would like to go to the other end of pregnancy for just a moment.

It is my understanding that the most critical damage that is done is during the first trimester or even the first month of pregnancy. So, we have a situation where a mother may be using crack cocaine and not even know she is pregnant.

Would you comment on what damage is done at that point during the first month or the first trimester?

Dr. ZUCKERMAN. There are different kinds of damages at different points in gestation, and the birth of a baby is only one other arbitrary point because damage can continue after that. The baby is exposed to dangerous events in utero, but also exposed after utero. And those of us who work in municipal settings see far too much abuse and neglect.

But what you should see in the first trimester is organ system damage which is rarely seen in cocaine exposure. Weight and length come out in the second two trimesters, and the brain continues to develop all throughout pregnancy and during the first few years of life.

Again, you are asking questions that in some ways, particularly regarding the brain which we are all concerned about, are unanswered. Cocaine changes levels of the body's own neurotransmitters. What that does to a developing brain is unknown. Is there a special sensitive period that is more critical than another? We do not know. These and other important questions are unanswered.

I think there is reasonable data to suggest that similar to alcohol consumption, if cocaine use is stopped during pregnancy, it will be to the benefit of the baby.

The paper you may be referring to about the baby still having a neurobehavioral disturbance when the mother stopped after the first trimester is important. But there is a lot of recovery from those neurobehavioral disturbances. We don't know whether these disturbances are permanent. We do not know that they are predictive to later outcomes. We do not even know whether these disturbances represent withdrawal effect. There could be a number of other mechanisms.

In reality, a crack-addicted baby is not an accurate term. Since there is no withdrawal, we cannot say for sure there is addiction. All these babies are cocaine-exposed. Again, I do not want to make light of the situation. I am concerned about the stereotyping particularly when we do not have adequate data to fully understand the extent and range and depth of the problem.

Mr. SHAW. Let me ask you one further question. You were talking about the way mothers react, and that during the first 6 months of pregnancy is really the time to get to them. We were over at D.C. Hospital before we came here this morning, and the comparison was made by one of the pediatricians over there that the crack cocaine mother seemed to be indifferent to the child whereas even the heroin or methadone addicted mother seems still

to have her internal instincts about her. Have you noticed that same comparison?

Dr. ZUCKERMAN. I see that, unfortunately, with a variety of mothers, including crack cocaine mothers, but not all crack cocaine mothers. I think that is the point. I think there is too much stereotyping. I do see that. That is very troubling. But there are some other mothers who really do care and really do want to make a difference. And I think we do not know what percentage fall in either part. But clearly, from some of the work we are doing and other work I see around the country, many women are responding to treatment programs. But, yes, that is a concern, and I do see it, but I do not believe it is the majority of women at all.

And I think there is a whole range of interest in responding to services and ability. We are seeing women who still have guilt and shame and really want something better for themselves and their baby. And our job is try and help them at that critical point in time.

Mr. SHAW. Thank you.

Acting Chairman DOWNEY. Thank you.

Mr. Coyne.

Mr. COYNE. Dr. Zuckerman, is it your sense that adoption agencies have refrained, for the most part, from making a determination that cocaine-exposed infants are unadoptable?

Dr. ZUCKERMAN. Well, again, I have heard that. It was mentioned at a National Academy of Sciences meeting I was at last week, that one of the adoption agencies has stated that they are unadoptable. Because of this stereotyping, the babies that need good homes may be deprived of this because of undocumented concerns. There is literally no scientific data about what the outcome is. We are all concerned, and certainly some babies are not going to do well, but I think we believe that some will do well.

We can all talk about our anecdotal reports. We really need information. I think we need information from the child welfare system. Of these women who are identified with cocaine exposed newborns, what happens to them and their babies 1 year later, 5 years later? To my knowledge, we have none of that information in any city anywhere. The system is not adequately monitoring the outcome of these families. This type of information is needed to make good decisions. How many people respond to treatment, how many people do not. What are the factors that help people respond to treatment. I am not talking about a fancy study. I am talking about the agencies responsible for the care of these children to know that of those infants exposed at birth, how many are still with their parents 3 or 4 years later, how many are thriving, how many have problems. To my knowledge, we do not have that information.

Mr. SHAW. Thank you.

Acting Chairman DOWNEY. Doctor, how long have you practiced medicine?

Dr. ZUCKERMAN. Eighteen years.

Acting Chairman DOWNEY. And how would you describe the problem when you started versus the problem today?

Dr. ZUCKERMAN. Cocaine is a new problem, and it is very difficult. I have yet to see an increase at Boston in the total number of

premature babies or the total number of children needing special education services. I believe this is probably an important and added-on problem to health problems related to poverty that have been destroying children for the last 10 or 15 years. This will make it worse. This will only make it worse. We have had every single one of these problems, behavioral problems in school. In Boston, well over 23 percent of the children need special education classes. This is as of 7 years ago before crack hit. Crack is going to potentially make it worse. It is an add-on to other risks associated with poverty. It is a very dangerous drug, but we do not know the long-term implication. The problems children are facing today are not new. Cocaine adds a new wrinkle, a very important and concerning one.

Acting Chairman DOWNEY. Thank you, Doctor. Thank you. Margie Clay is the program coordinator of the DEMAND treatment program in Minneapolis, Minnesota, and she will also address some of these same concerns. Thank you for being with us, Ms. Clay.

STATEMENT OF MARGIE CLAY, PROGRAM COORDINATOR, DEMAND PROGRAM, TURNING POINT, INC., MINNEAPOLIS, MINN.

Ms. CLAY. Good morning.

What I would like to do this morning is follow the same line as Dr. Zuckerman and talk about the profile of the women that I am seeing and also talk about the services that we are attempting to provide for these women. I need to also say that the model that we are using is not a guaranteed cure-all, but we are seeing about a 40 percent success rate with the women that we are working with.

First of all, I would like to say that I think out of sheer frustration and not knowing now to provide services for this population, a lot of communities and a lot of government officials are just throwing up their hands and saying that recovery is not possible. These women do not care about their kids. We need to build more prisons. We need to gear the school system up for this real behavioral problem, this unteachable child that is going to come through the school system. And I need to say that that is not true.

I need to say that treating the mom's addiction and not treating this addiction as a family disease is not going to help the family at all. Putting mom in treatment and not bringing the kids in with mom is not going to define the problem at all. Treating mom's addiction and then bringing those kids out of foster homes, putting mom in the house, putting those kids in the house, is only going to set mom up to use again.

The problem is much, much more than mom's chemical use. The problem started with mom I would say when she was about 3, 4 or 5 years old when somebody in her family decided to make her their sexual partner, when somebody in her family decided to abandon her, when she herself was neglected, when she herself did not receive the bonding or the nurturing she needed for healthy child development. Her drug use started as early as 5 or 6 years old which means that this lady has been using pretty much all of her life.

And you have to wonder what would cause a person—I mean, we know that kids start out experimenting with drugs at 5 or 6, but

what would cause a person to continue to use drugs all of their lives? What has happened to their self-esteem that they feel so bad about themselves that at an early age they have to use something to feel better about themselves?

When the DEMAND program started and we began to look at how we could better serve this lady and her children, we had to, first of all, figure out what she needed, what we needed to do to effectively reunify this family. If we treated the chemical dependency and not looked at the fact that she had been a victim, if we treated the chemical dependency and not looked at the fact that she did not know healthy parenting skills, if we treated the chemical dependency and not looked at the fact that she was low income and did not have any marketable skills to take care of herself or her family, if we treated the chemical dependency and realized that she had lived in poverty all of her life, if we treated the chemical dependency and not looked at the fact that she may have only finished ninth grade, if we treated the chemical dependency and not dealt with the fact that this 28-year-old lady could possibly have nine kids, what were we doing to this thing?

So, we set about putting together a program that would not just treat her addiction because it is really easy to keep somebody sober. I mean, all you have to do is lock them up for about 6 months and they will stay sober. But when you put them back on the street, all those same issues are there—all those same issues are there. And then you throw in the fact that this lady has probably given birth to a cocaine baby who she has no idea how to take care of, who is going to cry all night, who may have a hard time bonding with her, which makes this child a high risk for physical abuse or abandonment or neglect all over again.

Turning Point is excellent at providing chemical dependency treatment, but we were not a day care center. We were not a parenting program. We were not psychologists, and we knew that in order to be effective, we had to bring all of these resources together.

And one of the things I know is that people talk about we need to create new resources. The resources are there. The resources are there. It is case management. It is a matter of going out and meeting with all of these resources in the community and figuring out how all of this can be set into place.

When we started looking at the chemical dependency issues of the mom, one of the things about crack addiction is that the urge to use is so overwhelming. There are triggers that bring about the urge to use cocaine. Now, for me something as simple as a cotton ball is just a very simple cotton ball. But for a cocaine user, a cotton ball is a trigger to get high because I have used the cotton ball to smoke my crack. Something as simple as alcohol to me is just something that I rub on my arm, on my leg or whatever, but for a crack-addicted person, that is a trigger to get high. The first of the month for the women I work with is a trigger to get high because that is when they have money. And the environment that they got high in is a trigger to get high, a certain song, a certain outfit. All of these things are triggers to get high. When I feel sad, I get high. When I get lonely, I get high. When I feel happy, I get high.

So, we had to help these women to understand that you cannot change your environment because you are not going to be able to move anyplace else when you leave this treatment center. You basically cannot afford to move anyplace else when you leave this treatment center. You are going to be getting the same money that you were getting from welfare before you came into treatment. You are going to get that when leave out of here. You cannot afford to move anyplace else. You can change the clothes you wear, and you cannot be around cotton balls, and you cannot have alcohol around you. But you are going to still be sad. You are going to still be lonely. You are going to still be angry.

So, we had them list all of the triggers, everything that they could possibly think of, that would make them want to get high. And then we set about teaching them how to work through those triggers, how do you deal with sadness, how do you deal with loneliness, how do you deal with anger.

And then we looked at the fact that if all of these women were victims, how they must feel about themselves inside, the amount of shame and guilt that they must feel at finally being able to tell somebody that, yes, I am an incest victim, yes, I was sexually abused, yes, I was physically abused, and I do not feel good about myself.

And then you couple that with the fact that if you start looking at all of the things that these women have done to support their drug use, the bestiality, the sleeping in the crack houses, the sleeping with whomever they wanted to sleep with in the crack houses, the abandonment of the babies—because these women care about their babies. And that is probably the biggest misnomer I have heard since I have been working with this population of women is that they do not care about their babies. They do care about their babies.

And couple that with the fact that what they have heard from child protection is that you are not a good mom. You are a lousy mom, which adds more shame and more guilt to them. And then you couple that with the fact that a lot of the women have given birth to addicted babies. The babies are on apnea machines. So, they have to live with what their addiction has done to this baby. We need to work through the shame and the guilt that these women have. And there is kind of a twofold piece of shame and guilt because there was shame and guilt regarding their own victimization, and then there was also shame and guilt about what their addiction had caused them to do.

We had to quickly figure out a way to work through that. So, we started doing self-esteem groups. We started doing parent support groups. We started doing victim groups. We started teaching them healthy sexuality. We brought in a licensed female psychologist who could do individual sessions with these women to help them work through the shame and the guilt.

We also started doing grief groups because I have to grieve the loss of what I have been able to depend on to take me to a place where I could not find anything inside of me to take me there. So, you are telling me that I have to let go of what has been by friend, my lover, my all, my everything and replace that with what? So, you have to grieve the loss of the drug.

And then for a lot of the women, they have to grieve the loss of a child, and also for a lot of them grieve the loss of a normal child. And when I say normal child, a lot of these women are looking at children who were born with physical problems. It is not a normal child to them. So, we decided to do grief groups.

Then we looked at parenting, which I think for a lot of these women is perhaps the biggest setup because we say to them we want you to be healthy parents. Well, what is that? I didn't get nurturing, and I didn't get bonding, and I was abandoned, and I was neglected. What do I know about healthy parenting?

So, we needed to do parenting skills. We found an agency who not only will do parenting groups, but will do individual parenting sessions, will do parenting groups with the significant others of these women, will do whatever they need to do to help this lady learn healthy parenting skills, to help her learn how to cope with the fact that you have a high risk baby and this is how you are going to have to work with this baby.

We needed child care because we could not have 28 kids with us as we were attempting to do group, but we needed to have a child care who was not just going to look at the child and feed it and change its diaper. We needed to have a child development center who knew what working with a high risk child meant, who knew about crack addiction, who knew about the environmental effects of this drug on the children.

A lot of focus has been placed on the infant and rightfully so, but my concern is the older child of this mom who may have become the parent while mom was using, who may have seen all the sexual abuse, who herself may have been sexually abused and has not told anybody. The older kid who has been placed in a foster home, the older kid who has been separated from mom for up to a year, this was my concern.

So, we needed to figure out how we were going to provide services for this older child who is in a foster home because in our program even though it is a live-in situation and the mom and the kids are in treatment together living together, mom can only have two children with her, and that is zero to age 5. So, what about the school age child who is getting no services? So, we bring these kids in for programming 2 days a week and we allow them to talk about their anger towards their mom, to talk about their own abandonment issues, to talk about their own neglect, to talk about their fears, to talk about lack of trust, to talk about all the issues that their mom should have talked about when she was growing up but never got a chance to talk about.

That is the gist of our program. We have a total program, not just treating this lady's addiction. And we are doing this not by having her go to outpatient because it is not going to work, but by having her there in a supervised living facility for 6 to 7½ months.

But the problem comes when she leaves that facility. There is no housing. We say, OK, we want you to come to group twice a week and make sure you still go to your GED classes, and make sure you still go to your after-care group, and make sure you go to AA or CA. And child protection says, OK, now here are all the rest of your kids, and stay sober. It does not work like that.

First of all, she has to go back into the same environment that she moved from because she cannot afford to go anywhere else.

Second of all, if she moves, she cannot afford the rent. So, she ends up going back into this relationship where she was being physically abused all the time or the guy was selling dope, and eventually she is back into it again.

If she moves out of the environment, she has no transportation to get back and forth for after-care, and if she has transportation on the bus, who wants to haul around nine kids to a group?

So, we decided to do a little bit about that. What we said was, OK, we have this child development center set up, and you are already there. As long as you will go to after-care, your child can go with this child development program every day. As long as you continue in your parenting classes, your child can go to child development all day. As long as you comply with your after-care program, you do not have to worry about day care for your child because we will continue to take care of your child. We provide the transportation to and from after-care. We will do whatever we have to do to get these women to after-care if we have to baby-sit their children.

The problem is still housing. The problem is still when I leave treatment, I am scared to death. Even if I know and want and feel within I want to stay sober, I am scared to leave what has been a safe environment for me. I am scared to leave the staff that has been there for me. I am scared to leave these other 14 women who have been a support system for me. I am not ready to go. Why can't you have a three-quarter way house that will allow me another 6 months to work on me, that will allow me another 6 months to maybe get my GED, that will allow me another 6 months to continue to work on my parenting skills, that will allow me another 6 months for my visits with my kids in foster homes to go from a couple of hours to overnights to weekends? Give me some more time for me. That is a need for these women. That is a strong need for these women. They do fine in treatment. It is when they leave that treatment center and they are actually not ready to leave. Six to seven and one-half months is unreal because it takes you 4 months to get to the point where you have worked enough with the woman for her to finally feel like I want something better for myself. And if these women do not have a positive self-esteem and want something better for themselves, they will not stay sober. They will not stay sober. It has a lot to do with the way they feel about themselves.

I started out by saying that resources were there, and I want to end with two things. The resources to provide services for the women are there. What is not there are the facilities to put them in. In the State of Minnesota, the whole State of Minnesota, there are three facilities designed to have women and children in treatment together. My program will house 13. There is another program in Minnesota that will house six. There is another one that will house 10. That is unreal. That is absolutely unreal when you talk about the magnitude of women who are using drugs in Minnesota. I will answer any questions.

Acting Chairman DOWNEY. I have lots of questions. [Laughter.]

[The prepared statement of Ms. Clay follows:]

Statement of Margie Clay, Turning Point DEMAND Program

In less than a decade, crack, by far the most addictive drug that has ever been produced, has had a devastating effect on American Society, especially women and children.

Crack/cocaine cooked into solid form and then smoked produces feelings of exhilaration, confidence and omnipotence, but, its effects last only a few minutes. The crack smoker wants more and more, and, more is not enough.

Most women will do anything to get this drug. The price of crack has produced a group of crack whores; selling sex for crack, women who will spend rent money, milk or food money, sell food stamps, sell their furniture. As a result of this, children are victims of physical, sexual, and verbal abuse.

Use of this powerful, addictive drug during pregnancy is producing a generation of children born addicted. These infants have serious physical and developmental problems. How to provide services for the victims of this addiction continues to be a problem in communities for social service agencies, service providers and Government officials.

Out of frustration, too many government officials and communities throw up their hands not realizing that while the effects of crack are devastating. Recovery, though difficult, is possible.

Addressing the needs of the crack addicted family must focus on more than the chemical dependency. If we simply focus on the drug use of the women and not address all of the needs they have, we are simply setting this family up to return to the drugs.

In order to effectively provide services we must identify the needs. The profile of over 95% of the clients that the DEMAND program provides services for is the following:

1. 100% are poly drug users, meaning they have used alcohol, marijuana, speed, P.C.P., with first time use being as early as six or seven years old. Crack/cocaine is the choice of drug for all of the women we provide service for. Their drug use has caused them to lose all material possessions, and have ended up living along with their children in conditions so deplorable. Children being exposed daily to physical abuse, sexual abuse, incest.

2. 100% of the women have been victims of some form of victimization as early as three or four years of age themselves. They, themselves are children of chemically dependent families. They, themselves are victims of abandonment or neglect, thus, producing a very low self esteem. A large expectation we have of these women is that they be positive parents. We are finding out that their parenting skills don't include bonding or nurturing because they never received this themselves.

3. 90% of the women have no marketable skills which means they are not able to get jobs to take care of themselves or their children. 55% have only achieved a high school diploma. The average client is 24 years old with three or more children, all are single parents, and all are on A.F.D.C.

To say that we will simply treat the addiction and not focus on all of the other issues that this family brings into placement with them will not solve the problem. If we can put a sobriety way of life as a goal, then what services do we need to provide to help her reach this goal?

Being addicted to crack/cocaine produces physical and psychological urges so strong until something as simple as a cotton ball can produce the urge to use. When a person enters the DEMAND program, we began a process of identifying what it is that triggers the urge for you to get high. Money, a certain street, a time of the month, a time of the day, anger, sadness, loneliness, baking soda, flour, sugar, a certain person, a certain store; these are just a few. It is so very important that we teach these women how to identify the triggers and work through the urges for this destructive drug. When women come into placement they have a chance to really understand how they have neglected their children or really begin to understand what this drug is doing to them and their unborn child. The shame and guilt they feel, if not worked through early, can be a reason to leave treatment and go use; because regardless of what people may think or feel about these women they do love their children.

1. Crack/cocaine is the only drug that takes away the parental instincts. The physical need for the drug is so overwhelming. Women need to be able to take responsibility for what they have done, feel the shame and guilt, grieve the loss of this dependable friend - the drug, and for a lot of them, grieve the loss of a child, or a normal child.

2. Not feeling good about oneself effects every decision that a person makes. In order for a person to want a better life, a person must feel they deserve a better life.

It is vital for recovery that these women have began to feel better about themselves and feel they deserve to feel even better. To achieve this, women need to be able to do al lot of work on their own families of origin. What kind of messages did you get from your family? What role did you play? They talk about being alone, never feeling a part; being an incest victim, being physically/sexually abused. It is important they are allowed to work through the shame, anger, abandonment, neglect, or whatever has caused them to not feel good about themselves, has caused them to set up situations to only reinforce the negative feelings they have carried around for years, the feeling they have bee trying so many years to cover up by any means available.
Self esteem groups, women's groups, psychological therapy are a must. The chances of staying sober are slim if all you have done is kept me sober and not helped me work on what may be contributing to my use.

3. Crack/cocaine destroys families; children often taking over the responsibilities of the parent as far as taking care of younger children. Children being exposed to police raids, separation from parents, and, again, being victims long before birth.

We often find a place to put the mom in treatment and provide services for her, but, provide no services for the children. The goal, whenever possible, is to reunify the family.

This can only be accomplished if the family is treated as a family - together.

I firmly believe that more programs should be established that will allow mom and families to be in treatment together. This provides an opportunity for bonding and nurturing to develop between patient and infant. This provides an opportunity for mom to learn parenting skills and to have these skills monitored. This provides an opportunity for bonding and nurturing to develop between parent and infant. This provides an opportunity for mom to learn parenting skills and to have their skills monitored. This provides an opportunity for mom to gain confidence within herself as a parent. This allows mom to become comfortable in working with a baby who may have been born with physical and psychological problems due to mom's cocaine use during pregnancy.

These babies are often high risk for physical abuse or abandonment due to the frustration involved in working with them.

The DEMAND program has such a program that allows moms to learn how to parent their children while their children are with them in treatment. Providing parenting skills and child development classes for the women is imperative.

Providing therapeutic groups and individual counseling for the older children to allow them to work through the anger and lack of trust, the abandonment, the neglect, the victimization they have gone through is a must.

Job skills and educational needs are met by providing a Job Development program as well as having a public school G.E.D. program on site.

The medical needs are taken care of by High Risk Clinic at Hennepin County Medical Center, and a visiting nurse association

that monitors all of our clients. We provide nutritional counseling, teach budgeting skills; all of this is provided to the family as a whole. You have got a family healing together, recovering together, growing together.
Aftercare is a vital part of recovery. Treatment is the beginning of a process, aftercare provides that continued support to help recovery along.

Aftercare is more difficult than treatment. During treatment you have the safe and secure feeling of the facility being there for you. The staff being there for you and the other women being there for you.

This is an area that is of vital concern for me because this is usually when women relapse.

They have usually been in treatment for six months (hopefully) because anything less than six months in a supervised facility is not going to work. Have been in a safe environment for this length of time, are finally able to feel better about themselves and the positive choices they are making. Are going to their groups, are taking care of their children they are allowed to have with them (in our facility they can have two children ages 0-5) the other children are in foster homes, and have often been there for up to a year prior to service being provided for their family. We bring these kids in for therapy and start out with hour visits and work up to weekend visits. Keep in mind some of these women have four or more children. They complete treatment and have no place to go.

Housing is, perhaps, the biggest problem for these women once they complete treatment. They often end up having to go back into the same environment because they, financially, can't go any place else; back to selling dope to pay the rent, back to the same perpetrator who helps pay the rent, and are often given their children back when they are not really ready, and are told to attend your aftercare groups.

We need three quarter way houses, less structured than the treatment center. This would give the family another six months to grow, to find affordable housing, to develop a stronger support system, to continue working on the relationship with the older children, and to become more stable in their won sobriety.

Kids should be placed back with mom, not all at one time, but, with some months in between.

Aftercare must consist of transportation, child-care, parent support group, children support group. Continued psychological therapy is needed for the family.

In working with this population, case management is a must. It doesn't mean creating new resources. The resources are in place. If we can bring all of their resources together, we can provide a valuable service to this family.

Acting Chairman DOWNEY. We are going to hear from Ms. Denton and Mr. Horowitz and then ask all three of you questions.

Ms. Denton, if you would proceed. You oversee the Cook County Operations of the Illinois Department of Children and Family Services, and will discuss what services are available to drug-involved families and the issues that arise as crack children enter child protection and foster services and adoption systems, and whether or not current Federal child welfare laws are adequate to address this problem. Ms. Denton.

STATEMENT OF INA REDD DENTON, DEPUTY DIRECTOR, DIVISION OF COOK COUNTY OPERATIONS, ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Ms. DENTON. Thank you, Chairman Downey, Mr. Coyne, Mr. Shaw.

After hearing Ms. Clay, I feel that really very little more needs to be said because she has so graphically explained the plight of our children and their mothers.

Today I am going to talk some about the effect of cocaine on the child welfare system from a public perspective, and in particular the State of Illinois.

As deputy director of the Illinois Department of Children and Family Services for the Division of Cook County Operations, I am responsible for all of the mandated child welfare services in Chicago and the surrounding suburbs that comprise Cook County.

Although Cook is a relatively small geographical segment of the State, it accounts for 45 percent of all child abuse and neglect calls that come into our central State child abuse and neglect hotline. Over a 5-year period, from 1985 to 1990, the allegations of substance abuse in Cook County rose from 129 in 1985 to 2,200 in 1990. When I worked out the percentage on my computer, I thought I cannot even use it because it does not make sense to talk about thousands of percents.

In fiscal year 1989, nearly one child in three under the age of 1 that came to our attention with an indicated finding of abuse or neglect were born to women of color and were drug-involved. And 85 percent of the cocaine babies reported in Cook County are African American.

We know that the majority of the children and families become involved with the child welfare system because of cocaine abuse and that they are suffering a multiplicity of problems of which cocaine addiction, as Ms. Clay also mentioned, is but one factor.

We also know that many of the cocaine-abusing mothers have limited to nonexistent family and social supports. They have no one out there caring for them.

We know that the families indicated for substance misuse have an exceptionally high incidence of subsequent child abuse and neglect reports, many for second and third births of cocaine-involved infants. For that reason, in some of our early family intervention and family preservation programs, we are deciding not to provide those services for these children because we are fearful of putting them at risk.

We also know what is not working for these youngsters. After a tragic death of a little girl about a year ago in the home of her cocaine-addicted mother—the child fell out of a bed and was burned on a heater while mom was strung out—I appointed an in-house committee from my field to talk to field workers about their experiences with this problem of cocaine.

The child welfare supervisors and the child welfare specialists on the committee interviewed 74 of their colleagues about their experiences and submitted a report to me with very sobering findings. They revealed that little of our presently available services were working. In fact, they wistfully talked about the good old days of heroin. In-home support services, community referrals, judicial orders, counseling and the usual routine support and surveillance simply have not had an impact. This highly addictive drugs and those who prey on its users hold sway over these despair-ridden mothers.

The staff overwhelmingly recommended in-patient treatment for parents and child care outside of the home during the course of the treatment, hopefully with the mothers in treatment. These observations and recommendations come from a very savvy street-wise staff who have many more successes than failures and have a long history of working with the most impoverished, both in spirit and pocket, client groups that our society creates.

These findings, based upon our experience in Illinois, to me give dramatic testimony to the fact that the use of cocaine by women during their childbearing years is wreaking havoc on the child welfare system and stretching our resources to the limit. We are trying to use the tried and true and it is not working. Judges who are frustrated order us to provide more of the tried and true, and then they are frustrated when the worker comes back either saying the mother did not go, we could not get her there, or there has been no change in the family.

Workers are increasingly frustrated by the seeming intractability of cocaine upon the families that they serve. They are stymied by the lack of appropriate and timely—I must emphasize timely—treatment programs. Many mothers get on waiting lists for a drug program that is in excess of 6 months long.

We also are stymied by the dearth of specialized placements for our cocaine babies. People are afraid to care for these children. They are afraid they are going to die in the night and they then will be investigated for the abuse of the child. They are afraid of their family being so disrupted by a child who stays up all night, who cries, who cannot develop a relationship with the foster parent that is so important.

They are stymied by the difficulty of engaging cocaine-abusing mothers in a successful intervention process. Child welfare systems in our country find themselves directly engaged in the crisis our society is experiencing. There are few of us who can avoid being deeply affected by the site of seeing the infants just a few days old struggling for life in specialized intensive care nurseries across this country. I have held babies in my hand not larger than a kitten and have felt all of their limbs so tense in seizure that I was very afraid the child was dying before my eyes. You have just completed

such tours today. What you saw today is what my staff is experiencing many times every day.

Throughout this country many of us now are wanting to make a difference. However, there are some who believe that the solution rests in punishing the user, dispensing with title IV-E/IV-B reasonable efforts mandates. There are some who believe that the cocaine-addicted woman is nothing but an unsalvageable criminal. The powerful emotions experienced when one sees the effect of the drug on the innocent babe can tempt us to a quick solution, the neat and tidy answer that will allow us to feel, but only for the moment, that we have done something and that we are back in control.

I suggest, however, that in the current crisis, there are seeds of opportunity. Rather than discarding the current legislation which provides for reasonable efforts, should we not instead look at the reasonableness of the effort? Does the effort truly address the parent and the patient's need? Is the medical problem, the addiction, treatable given the resources at hand? Is an appropriate resource available?

As I said before, many women must wait for months for service. If I have an appendicitis attack, you are not going to put me on a waiting list. You are going to operate on me within the moment. The reasonable effort must directly relate to the problem that is interfering with mom's ability to parent, and the reasonable effort must directly relate to helping her regain parenting or learn parenting skills. The usual reasonable efforts simply do not work.

Although the temptation might be to blame the victim, or remove the child, I hear some people say take all of the children, put them in foster care. I suggest a more fruitful and long-lasting approach is to think clearly about how the cycle of addiction can be broken. And this morning you have heard an example of how that can happen. Alleviation of the problem requires a continuum of services. The key is a continuum that is respectful of the individual and the community's needs and does not do half the job. We are very good at half the job.

Dr. Peter Bell, the executive director for a national institute which focuses on addiction among African Americans and is headquartered also in Minneapolis, sees the continuum has having five components: one, drug education; two, primary prevention; three, diagnosis and intervention; four, primary treatment; five, aftercare. More than anything else, he stresses the importance of aftercare. In his words, he says, "It is easy to get people off chemicals, it is difficult to keep them off."

Intervention programs will not be successful if they stop after primary treatment. Too often we put the majority of our time and dollars in education, a little less in prevention, a little less in primary treatment, and then fail to support adequately the long haul of rehabilitation and reintegration into a drug-free lifestyle. Then we blame the parent for falling off the wagon.

Illinois, through the Departments of Children and Family Services, and Drug, Alcohol and Substance Abuse, and Public Aid, is in the midst of some new program development that we are quite excited about that should employ the knowledge of substance abuse and child welfare in a comprehensive manner of linking together

disparate resources. We are jointly developing, through grants to the private voluntary agency sector, programs for the treatment of pregnant and parenting women, such programs as what we call the integrated family intervention team that will be able to assess these moms at the point of the birth of the baby, offer treatment to her either in-patient or community based, get services to her to help her with the level of parenting skills that she needs and treat her substance abuse, misuse or addiction wherever she is on that continuum.

We also have a program called the Drug-Free Families with a Future that is heavy in outreach, getting parents involved in a network of services, a one-stop shop again, as Dr. Zuckerman talked about, within the community. This is just in one community in the city. We would like to see it all over. We are trying to see what we need to do to make it work well.

We are also adding some new detox programs for mothers who need that. And then the key that we are most excited about is the development of two to three residential treatment programs where mom and baby can be together. It is difficult to remove the intervening love of mother so that she can love her child, unless we have mother and child together. The hopelessness of being told that you are so awful that you even lose your child is something that often these moms do not recover from. Then after the residential programs, we move back into the Drug-Free Families with a Future for after-care support.

We are excited about the future of such programs. Our initiatives are based on the belief that the these mothers, even those who abandon their babies at birth or neglect and harm—seriously harm I might add—these children would act otherwise if appropriate treatment were offered and if the mother were given a viable alternative to her addiction and the loss of her children.

If we can withstand the pressure to do things without a lot of thought and without solid planning, if we can serve a few for the long haul instead of being forced to partially serve many so that our statistics look good, if we are allowed to make a few mistakes, learn from them and correct our course, we will have contributed greatly in child welfare to the war on drugs.

These programs, however, will not be cheap. Although the per diem costs are not yet calculated, I would suggest that the residential care per family group will be somewhere between $15,000 to $20,000. However, the indirect costs of lifelong dependency and continuation of the cycle, hidden in medical care, special education, court hearings that go on and on, incarceration, foster care payments, subsidized adoption payments, public assistance grants, those total costs are far beyond the bill for quality drug treatment and after-care.

Finally, I would do all public and private child welfare professionals disservice and ultimately the cocaine-addicted adults and their involved children, if I did not close with a caution. Too often we settle for too few dollars, resulting in too little assistance. Then we child welfare professionals attempt to make do providing inappropriate and inefficient service. We are too timid in our asking for resources. We are too willing to spread the available resources so thin that no one gets enough to get better. And then we wonder

why social workers are accused of ineffectiveness and are seen as practicing an exact science. It is analogous to a physician taking out one tumor when she sees two, or performing the operation, but foregoing sutures because there is no money for needle and thread. The competent professional does only what she can, does not deceive herself or others by pretending that inadequate is sufficient.

Therefore, I urge that we risk doing the unpopular, that we refuse to engage in the pretense that a dollar cure can be effected with a dime, that we only agree to provide comprehensive quality care. Our collective cowardice in this Nation in stating the true need and complete solution has often led us into program design and implementation that, by its limitations, does the greatest harm to the recipient. We destroy their faith in themselves, the care giver and this society that has treated some of us so very well.

Our motivation to serve these families and children must come from the ethical principle of doing what is right. We must no longer engage in resource driven diagnoses, but instead we must commit ourselves to results-oriented treatment. It is a simple method of serving our clients. The members of the society in desperate need deserve nothing less than our integrity and courage to advocate for them based on what we know is essential, to treat addiction and the social conditions that exacerbate that problem.

We tend to be a society that fixes its attention on issues of critical importance only as long as the media record our catchy sound bites. It is very tempting for us in the public eye, elected officials or bureaucrat, to quickly move on to the next crisis. I know the one sitting on my desk when I get back this evening, never finishing one job before we tackle the next. Yet, we know better. We do know better. We know that the addicted mother needs more than 3 minutes on tonight's news. Perhaps we will stick with this issue because we have seen the children. We realize that behind the statistics our babies and mothers and fathers and brothers and sisters who are hurting and have been hurting in our society for a very long time.

It has been an honor to share my thoughts with you. Thank you.

[The prepared statement of Ms. Denton follows:]

INA REDD DENTON, Deputy Director for the Division of Cook County Operations, Illinois Department of Children and Family Services, 100 W. Randolph street, Chicago, Illinois 60601, 312-814-6834

Acting Chairman Downey and Members of the Subcommittee:
Thank you for inviting me to address the Subcommittee on the impact of cocaine on the child welfare systems of the country and, in particular, upon the child welfare system in the State of Ilinois. I am a Deputy Director of the Illinois Department of Children and Family Services (DCFS). My role within DCFS is to administer the Division of Cook County Operations, which is responsible for providing mandated child welfare services within the City of Chicago and the surrounding suburbs of Cook County, Illinois.

Although Cook County comprises a relatively small geographical segment of the State of Illinois, it accounts for 45% of all child abuse and neglect reports in the State and is the origin of 90% of all substance abuse allegations called into the State's Child Abuse and Neglect Hotline. Over a five year period (1985-1990), allegations of substance misuse in Cook County rose from 129 in 1985 to a projected total of 2,200 for fiscal year 1990. In fiscal year 1989, nearly one child in three under the age of one year in a case reported to the Hotline was for an allegation of substance misuse. In Cook County, nearly one child in two, or 50% of the children in indicated cases fell into this category.

The number of children affected by the misuse of drugs is having a devastating effect on our community's children, evidenced most graphically at the point of entry to Cook County public child welfare custody, the Columbus-Maryville Reception Center, where children needing immediate protective custody are brought by police or child protection investigators. One recent morning forty-nine children in this one hundred-bed reception center were infants, most medically complex, most on Apnea monitors, better than half "cocaine babies." Babies that are small, sick, in serious need and without a place to go.

Based upon our experience in Illinois, what do we know about "cocaine babies" and their mothers? We know that in Illinois, cocaine - involved babies are twice as likely to die in infancy as are other children of the same age and background who are indicated for reasons other than cocaine abuse. We know that almost one-third of reported infants under the age of one year are drug exposed infants. We know that the majority of cocaine babies who enter the child welfare system in Illinois are born to women of color. Eighty-five per cent of the cocaine babies reported in Cook County are African-American.

We know that the majority of children and families who become involved with the child welfare system because of cocaine abuse are suffering from a multiplicity of difficulties of which cocaine addiction is but one factor. We know that many of the cocaine abusing mothers have limited to nonexistent family and social support systems. We know that families indicated for substance misuse have an exceptionally high incidence of subsequent child abuse and neglect reports, many for second and third births of cocaine affected infants.

We also know what doesn't work. After the tragic death of a little girl in the home of her cocaine addicted mother, I appointed an in-house committee from the field to talk to field workers about their experiences with the growing population of cocaine cases.

The child welfare supervisors and child welfare specialists on the committee interviewed seventy-four of their colleagues about their experiences and submitted a report with sobering findings. They reveal that little of our presently available services work. In-home supportive services, community referrals, judicial orders, counselling and routine support and surveillance simply have little impact. This highly addictive drug and those who prey on its users hold sway over these despair-ridden mothers.

The staff overwhelmingly recommended inpatient treatment for parents and child care outside the home during the course of treatment. These observations and recommendations come from a savvy, streetwise staff who have more successes than failures and have a long history of working with the most impoverished, in spirit and pocket, client group that our society creates.

These findings, based upon our experience in Illinois, give dramatic testimony to the fact that the use of cocaine by women during their childbearing years is wreaking havoc on the child welfare system and stretching our resources to their limits. Workers are increasingly frustrated by the seeming intractability of cocaine addiction upon the families they serve. They are stymied by the lack of appropriate and timely treatment programs needed by clients, the dearth of specialized placements for "cocaine babies" who enter protective custody, and the difficulty of engaging cocaine abusing mothers in a successful intervention process. Child Welfare systems in our country find themselves directly engaged in the crisis our society is experiencing.

There are few of us who can avoid being deeply affected by the sight of seeing infants, just a few days old, struggling for their lives in specialized intensive care nurseries in hospitals across the country. I have held babies not much larger than a kitten, having seizures that stiffen every limb. You yourselves have just completed a tour of such a nursery in this very hospital. What you say today, what my staff experience many times every day, must lead you and others throughout this country to want to make a difference.

There are some who believe that the solution rests in punishing the user, dispensing with Title IV-E/IV-B "reasonable efforts" mandates. There are some who believe that the cocaine indicated woman is an unsalvageable criminal. The powerful emotions experienced when one sees the effects of this drug on the innocent baby can tempt us to seek the quick solution, the "neat and tidy" answer which will allow us to feel, for the moment, that we have at least done something, and are in control.

I suggest, however, that in the current crisis these are the seeds of opportunity. Rather than discarding the current legislation which provides for "reasonable efforts," should we not, instead, reflect upon the reasonableness of the effort? Does the effort truly address the parent's needs? Is the medical problem, the addiction treatable given the resources at hand? Is an appropriate resource available? Many women must wait for months to receive drug treatment that is appropriate to their addiction.

The "reasonable effort" must directly relate to the problem that is interfering with the ability to parent and the ability to regain parenting. Usual "reasonable efforts" such as counselling, homemakers and emergency finances, as examples, are not "reasonable" treatment for the core problem of cocaine dependency.

Although the temptation may be to "blame the victim," or remove the child, a more fruitful and long lasting approach is to think clearly about how the cycle of addiction can be broken. Alleviation of the problem requires a continuum of services that is respectful of individual and community needs, and does not do half the job. Dr. Peter Bell, Executive Director for a national institute which focuses on addiction among African-Americans and is headquartered in Minneapolis, MN, sees the continuum as having five components: drug education, primary prevention, diagnosis and intervention, primary treatment and after care. More than anything, he stresses the importance of after care. In his words, "It is easy to get people off chemicals, it is difficult to keep them off."

Intervention programs will not be successful if they stop after primary treatment. Too often we put the majority of resources in education, prevention and primary treatment, but then fail to adequately support the long haul of rehabilitation and reintegration into a drug free life style.

Illinois, through the Departments of Children and Family Services and Drug, Alcohol and Substance Abuse, is in the midst of new program development that will employ the knowledge of substance abuse and child welfare. We are jointly developing, through grants to the private voluntary agency sector, four programs for the treatment of pregnant and parenting women. The programs are early identification, inpatient treatment, residential treatment and supportive aftercare. These innovations include identification and intervention immediately after delivery, residential care that includes the baby in residence with mom during her treatment except for a period of detoxification, should that be required, and community support and aftercare.

We are excited about the future of such programming. Our initiatives are based on the belief that these mothers, even those who abandon their babies at the time of birth, or who neglect or harm their children, would act otherwise if appropriate treatment were offered and if the mother were given a viable alternative to her addiction and the loss of her children.

If we can withstand the pressures to do things without a lot of thought and solid planning, if we can serve a few for the "long haul" instead of being forced to partially serve many so that the statistics look good, if we are allowed to make a few mistakes, learn from them and correct our course, we will have contributed greatly to the "War on Drugs." And we will have saved some lives, physically and emotionally.

These programs are not cheap. Although the per diem costs are not yet calculated, I would guess that the residential care per family group will be somewhere between $15,000 and 420,000. The indirect cost of lifelong dependency and continuation of the cycle, hidden in medical care, special education, court hearings, incarceration, foster care payments, public assistance grants, is far beyond the bill for quality drug treatment.

I would do all public and private child welfare professionals a disservice, and ultimately the cocaine addicted adults and their children, if I did not close with a caution. Too often we settle for too few dollars, resulting in too little assistance. Then we child welfare professionals attempt to "make do," providing inappropriate and insufficient service. We are too timid in our asking for resources. We are too willing to spread the available resources so thin that no one gets enough to get better. And then we wonder why social workers are accused of ineffectiveness and are seen as practicing an inexact science. It is analogous to a physician taking out one tumor when she sees two, or performing the operation, but foregoing sutures because there is no money for needle and thread. The competent does only what she can, does not deceive herself or others by pretending that inadequate is sufficient.

Therefore I urge that we risk doing the unpopular, that we refuse to engage in the pretense that a dollar cure can be effected with a dime, that we only agree to provide comprehensive, quality care. Our collective cowardice in stating the true need and complete solution has often led us into program design and implementation that, by its limitations, does the greatest harm to the recipient. We destroy their faith in themselves, the care giver and this Society that has treated some of us so well.

Our motivation to serve these families and children must come from the ethical principle of doing what is right. We must not engage in resource - driven diagnoses, but instead we must commit ourselves to results - oriented treatment. Our clients, the members of this society in desperate need, deserve nothing less than our integrity and courage to advocate for them based on what we know is essential to treat addiction and the social conditions that exacerbate the problem.

We tend to be a society that fixes its attention on issues of critical importance only as long as the media record our catchy "sound bites." It is very tempting for us in the public eye, elected official or bureaucrat, to quickly move on to the next crisis, never finishing one job before tackling the next. Yet, we know better. We know that the addicted mother needs more than three minutes on tonight's news. Perhaps we will stick with this issue because we realize that behind the statistics are babies and mothers and fathers and brothers and sisters who are hurting, and have been hurting for a long time.

It has been an honor to share this time with you. Thank you.

IRD: 4/90

Acting Chairman DOWNEY. Thank you, Ms. Denton.
Mr. Horowitz.

STATEMENT OF ROBERT M. HOROWITZ, ASSOCIATE DIRECTOR, CENTER ON CHILDREN AND THE LAW, AMERICAN BAR ASSOCIATION

Mr. HOROWITZ. Thank you. I am Robert Horowitz, associate director of the ABA Center on Children and the Law. I am going to present a very abridged version of my written remarks. One is time, and two, I think you will find tremendous agreement among this multidisciplinary panel, and I view that as encouraging. Maybe we do have some answers or at least some hope so we do not have to fight amongst ourselves, which we often do.

I have been asked to address the issue of the status of coercive State intervention into cases involving drug use by pregnant women. The different types of intervention I will briefly discuss will be public health, child welfare and criminal law. In the interest of time, let me begin by summarizing what I think are my main points.

The first one is that any State intervention into this problem demands a well-coordinated, multisystem, multiagency effort.

Second, the first State response must be a public health one. Without understanding the treatment and prevention resources that are available and that work, any criminal and child welfare interventions will be viewed out of context.

Third, the constitutionality of State intervention in these cases, especially during the prenatal stage, is remarkably undecided. No court has yet to squarely address most of the constitutional issues raised by these cases in the specific context of prenatal substance abuse. Thus, we simply do not know and probably cannot predict at this point how the courts will decide ultimately constitutional challenges to some of these very complex questions.

Finally—and I think this is a point directed to this subcommittee as much as anyone—I would like to say that in my view, many of our existing child welfare laws, if properly used, are adequate to address this problem, and that the greatest attention should be placed on assuring that the that the systems have the resources and—now I have learned—the facilities to effectively deal with these cases. In other words, I agree with Dr. Zuckerman that this is yet one more pimple on the problem of child welfare. We need the resources to handle it, but there will be other problems down the road.

Let me begin then with brief comments on public health. I am going to skip right to the point of public health that may be deemed coercive. We all agree I think that we need to have more in the area of prevention, education and treatment programs, and in my testimony I have given you some examples of recent State law developments. But there comes a time when public health interventions may fail, and there may come a time when some people want to start talking about the use of civil commitment proceedings to involuntarily commit pregnant women during the period of their pregnancies. Most States already allow for the civil commitment of drug and alcohol abusing individuals if other crite-

ria such as demonstrable dangerousness to themselves or others are met. Thus, we have not seen States in their civil commitment laws singling out this population for special treatment.

The one exception is in Minnesota—and if I make any misstatements about Minnesota, I am sure I will be corrected——

Ms. CLAY. Yes. [Laughter.]

Mr. HOROWITZ. Minnesota in 1989 enacted probably the most sweeping—I do not want to say comprehensive, but I certainly will say most sweeping—State intervention law to date. It combines aspects of civil commitment and child protection intervention depending simply on the time of the intervention.

Under Minnesota law, a mandated child abuse reporter, who "knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during pregnancy," must report this to the local welfare agency. This agency must immediately assess the situation and offer services. If the woman refuses or fails treatment, then the agency may initiate civil commitment proceedings. By treating this as a civil commitment and not as a child protection case during the prenatal period, the State arguably hopes to avoid the constitutional challenges based on a pregnant woman's privacy and bodily integrity interests. In theory this commitment may be based on a parens patriae ground, that is, the woman is unable to care for herself or engage in behavior such as seeking the treatment that would ameliorate her problem. In short, the commitment is for her benefit and not for the benefit of the fetus.

While civil commitment is a possibility for substance-abusing pregnant women, it like any other form of coercive State intervention is purely punitive in the absence of appropriate treatment. Experts in the mental health field who have looked at civil commitment processes would all agree to this.

Moving on to child welfare law, I would like to divide my comments into three issues: one, the making of a child abuse report; two, proving a case in court; and three, the types of dispositions we may see.

Several States, such as Florida, Illinois, Indiana, Massachusetts, Minnesota, Oklahoma and Utah, have recently amended their child abuse laws to specifically address the issue of pregnant women's drug use. While too few to call a trend, the direction has been towards defining specific situations where a child abuse report must be made after birth based upon again the pregnant woman's drug use.

The opponents of this reporting raise the slippery slope argument. They assert that once you penalize prenatal drug use, other lawful activities potentially harmful to a fetus will be included. Thus, a pregnant woman may face punishment for drinking liquor, smoking cigarettes, exercising, dieting, or a host of other activities. Furthermore, since we do not know exactly what activities are involved, they run the risk of being punished for conduct that they had no reason to suspect. This is a serious concern and one which policymakers need to be on guard for. State legislators have so far been careful in drawing lines. They have limited reporting to infants who test positive for or appear dependent on illegal drugs, or in some cases, if they exhibit signs of fetal alcohol syndrome. Fur-

thermore, several States have qualified this by excluding drugs taken pursuant to a prescription or as part of a chemical dependency treatment.

Another thing to note about these laws is that in mandating the report based upon a newborn or an infant's status, they do not apply to the prenatal period. By authorizing only postbirth intervention, these laws again may skirt the constitutional objections that could be raised.

I would also like to note that with the exception of Minnesota, none of these laws address the very controversial issue of testing. Although they may mandate a report upon a positive toxicology test of a newborn, other than Minnesota, they have no requirements that a test be conducted. On the issue of testing—and I will be brief on this—there are several concerns when policymakers start enacting mandatory testing or talking about testing.

One, simply the accuracy of a test. If we are going to base a case upon a test, we have to recognize that there are false positives and false negatives.

Second, the short detection period. As we have heard from many people, crack cocaine may disappear from the body within 72 hours of its last use.

Third, the test will tell us nothing about casual versus chronic use of the drug. So, the test result does not tell us about addiction or the rate of usage of any drug.

Fourth, there is always the possibility of discrimination when we test because whom we decide to test may be the poor, pregnant woman who has not had health care, which may be as indicative of her poverty situation as her drug use.

And lastly, we have the issues of consent, especially with the newborn. Can we take a toxicology test of a newborn without parental consent?

Before moving off from the subject of reporting, I just want to pose the question of whether or not in the absence of these kinds of specific laws that talk about drug dependency, we can report a child who is born and manifests some sort of drug dependency. To date, when I pose the question to groups of child welfare professionals, I get different answers. Some people think that their existing child welfare law would allow them to make a report simply because of a positive test. Others say we need to look at additional factors, such as the current status of the woman, the family support in her household, the environment, her job status, whether she has denied using drugs, whether she is on treatment, and a host of things. Right now I think it is best to say that nationally you are going to get a mixed response to the question whether under your State child abuse and neglect law, which has not been amended or specifies drug-exposed babies, you have to report a newborn that is drug-dependent. The answer will vary depending on where you are.

A second question is whether you can report, based upon your general child abuse and neglect laws during the prenatal period because you know the pregnant woman is using drugs. Right now the state of the law is, as we have seen from courts that have looked at this issue and the opinions of some State attorneys general, no: you cannot report during the prenatal period. That answer is based

upon statutory construction and not constitutional law. The State laws that these courts have looked at refer to children—any child in danger of abuse and neglect, children who have been harmed, and the courts have interpreted children to not include the fetus. They have left open the door, however, to whether or not State legislatures could come in and with some legislative language include fetus in this definition of child. Again, the courts have been reluctant to give us any constitutional guidance and have taken the easy way out of statutory construction.

In this field we do get a lot of concern from people about what do we do with that positive toxicology test. In some States, as I suggested, we report the person to the child welfare agency. And a lot of people are upset by that. They say that this seems to be rather skimpy grounds to initiate a child abuse report.

I would like to pose this issue in another way, however, that if the evidence is such that substance abuse by a pregnant woman poses the possibility of future harm to a child, once that child is born, due to the parent's addiction or lack of parenting skills, then a State inquiry may be appropriate.

We do not have to assume child protection services should be the persons making that inquiry. We could say public health authorities should make that inquiry. We could say a hospital social worker should make that inquiry, or we could say public health and child welfare together shall make that inquiry. When we go around the country, I think the programs that respond best to these kinds of reports are those that combine the expertise of public health nurses and child welfare investigators so that you have the two making the case assessments.

Where this whole issue, though, becomes most troublesome is in court and whether evidence of drug dependency or fetal alcohol syndrome by a newborn constitutes a prime facie case of child abuse and neglect. That means that if you have a positive test, the State has proven its case and you shift the burden to the woman to prove that she is not such a terrible person, that she is now drug-free, that she is in treatment, that she is in therapy, that she has gotten a job, that she is married, or has family supports.

We do not again know how the courts, if they are ever asked to review this, will ultimately rule on the issue of prima facie and shifting burdens, but let say that when you shift the burden to the woman, you risk the chance of doing two things. First, you give child welfare agencies an excuse not to do their job. They do not have to do detailed case assessments if they say, "hey, we will just go to the court. We have a positive drug test."

Second, you are going to elongate the process because the women will have to defend themselves, and it is going to take them longer to defend themselves than for the State to prosecute.

Most courts that have looked at this question have decided that evidence of drug use during pregnancy by itself will not sustain the court's child abuse and neglect jurisdiction. It may be probative, a factor to consider just like evidence of past drug use by a parent at another point in her life would be a consideration. But you still need to introduce evidence that is more contemporary in time. What is the status of this family today, and what is the likely status of the family tomorrow, not whether 3 months ago, 4 months

ago, 5 months ago while the woman was pregnant she used crack cocaine.

Assuming that the State has found abuse or neglect based in part on a woman's prenatal drug use, these cases should be handled like any other in the child welfare system. That means reasonable efforts, case plans, and periodic reviews.

When placed in the context of the parental substance abuse, these requirements raise several recurring questions. First, when is it safe to leave a child in a household with a drug-abusing mother? Second, what services are available and work with these mothers, both family based and out of home? And third, how much time do we give the mother to improve? While we always ask these questions in a court of law, they really do not demand legal answers. They demand answers that look to, one, the drug status of the mother and, more importantly, what treatment and services can the community offer. Let me give you an example of what I mean.

If the best treatment for a cocaine-abusing woman is long-term residential drug care augmented by other social services, such as job training and follow-up housing assistance, and if the community cannot offer these services, then early termination of parental rights might be what is best for the child. It may not be fair to the mother, but if that's all the community can do, that may be the reality we are faced with.

I am going to skip a lot of my remarks because they just follow up on what Ms. Denton said about the need for services and a coordinated case approach. I could not agree any more wholeheartedly that this is an interagency responsibility. And I think one of the encouraging things is even before crack cocaine became a problem, the child welfare system was recognizing that the lack of agency coordination was a problem, especially for infants, young toddlers, and children at risk. We are seeing more and more, at least at the State legislative level, movement towards enhancing, encouraging, promoting interdisciplinary cooperations.

You get to a point, however, where you may have to terminate parental rights. We all have heard hearsay that it is really hard to terminate parental rights and that there must be something fundamentally wrong with State laws. How can we allow this case to go on and on and on and on? My written statement gives a little bit more background and detail, but let me say a few comments on this.

When we look at grounds to terminate parental rights, several may apply to this situation. One may be that the parent's condition or incapacity is so great that that parent can never take care of their child, and we need to terminate based upon some kind of a parental incapacity that is longstanding, permanent, and not likely to change.

Second, we may terminate because we developed a very nice case plan for this parent, and they failed to abide by it, and they have not remedied the situation, necessitating removal.

And third, we may terminate because of abandonment.

Now, a couple of things to note. First of all, everyone thinks that this takes many years to do, that you have to abandon the child for 3 years, that you have to give the parent 4 years to try to remediate their problems, et cetera. Well, if it takes 4 years, I would

argue, it is not because the law says it has to take 4 years. If it takes 4 years, it is because we do not have the resources to process these cases in a timely fashion.

For those of you who saw yesterday's Washington Post story about how six attorneys are trying to handle the whole child abuse and neglect case law in D.C., you can imagine how termination actions get delayed, put off, postponed, because those are not the emergency cases. You have to worry about the kids in the house who are currently being abused.

So, it is not that the law necessarily says, give 4 years, give 5 years, it is just that the system cannot process these cases in a timely fashion. And admittedly, some attitudes also go against expeditiously handling these cases. The law, however, never talks about 4 years. The law gives many avenues where these could be done more expeditiously and quickly.

So, again, before we point fingers and say we have to change the law—how can we have babies abandoned for 1 year—let's look at the law and let's see if we are applying it.

Let me just close by mentioning briefly criminal law prosecutions, which is probably the most controversial aspect of State intervention. It is happening with increased frequency, but compared to what child welfare people are facing, it is less important.

Prosecutions based solely on evidence of a pregnant woman's drug use have been mostly unsuccessful. They have been unsuccessful because courts have either found that the State law that the prosecution was based upon does not apply or because, quite frankly, there are questions of proof. For example, in a recent case in Wyoming concerning fetal alcohol abuse, the State could not prove that the pregnant woman was actually harming the fetus at the time. You almost had to wait for the child to be born to be able to see the damage.

But some prosecutors will not give up, and as we have found out, and will use other tactics to get these cases through the system. One approach done in D.C. and elsewhere, involves pregnant women in front of the criminal justice system on an unrelated charge, put them in jail, deny them probation, deny them parole, have an excuse to keep them in prison during the period of their pregnancy.

Another approach involves creative charging, such as in Florida and elsewhere, where women have been prosecuted upon the point of giving birth to the child because the harmful drug passes through the umbilical cord not while the child is not a fetus, but outside the womb. At that point in time she is charged with delivering a controlled substance to another party. While there have been few successes, there has been a lot of publicity and a lot of fear among pregnant women, and that is very important.

Regardless of the charge or the time it is brought, these criminal actions have engendered the most heated debate over the use of coercive State intervention. On the one side are prosecutors who, while usually expressing distaste for such prosecutions—I have yet to meet a prosecutor who really likes to prosecute these cases—see these as a necessary leverage to get women into treatment and to send a message to the community.

On the other side are those who fear that criminal sanctions against pregnant women will cause them to shun prenatal health care visits and hospital deliveries and even encourage abortions. They also dispute whether the coerced treatment approach works for this population.

And lastly, there are a slew of constitutional challenges brought when such criminal actions are raised, including the woman's privacy interests and the due process problem of penalizing otherwise lawful behavior. It is not illegal to drink in this country, but we can penalize in theory a woman for drinking while pregnant.

And my favorite, the equal protection argument, which is that we are not prosecuting men, although there is some evidence—I have no idea how good it is—that semen of men, who are alcohol and substance abusers, may become defective and in turn may cause fetal harm.

In a nutshell on the criminal side is it's headlines, it's chaos. I think it has adverse consequences on health care, but we are not seeing a lot of convictions or prosecutions.

I will not read, but I will point you to the last page of my written statement which was the findings of a survey we did in the State of Washington at the invitation of the Division of Alcohol and Substance Abuse. It was based upon an interview of lawyers, judges, prosecutors, chemical dependency experts, doctors, psychiatrists, a whole slew of professionals involved in this problem.

The six main findings conclude my testimony. Surprisingly, there was largely consensus on how to handle these cases. The first point was to treat this as a public health problem. We need to deal with this prevention and treatment. The last point was let's not go getting heavy-handed with these people if we cannot offer them those kinds of services.

Thank you.

[The prepared statement of Mr. Horowitz follows:]

STATEMENT OF ROBERT HOROWITZ, AMERICAN BAR ASSOCIATION

Mr. Chairman, and Members of the Subcommittee:

I am Robert M. Horowitz, Associate Director of the Center on Children and the Law, a program of the American Bar Association Young Lawyers Division. Since 1978 this Center has focused intensively on improving the legal and child welfare systems' response to the needs of children and families. Early in 1988, our Center began receiving, almost daily, calls from child welfare and health professionals, judges and prosecutors seeking information on state intervention in cases involving drug use and alcohol abuse by pregnant women. This led to our identifying, collecting and analyzing relevant statutory and case law developments.

I would like to share with you some of our observations. While much of this is addressed in our recent publication, Drug Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protection Systems, none of the following should be construed at this time as policies or positions of the ABA. In my statement, I will briefly address three different state intervention options: public health, child welfare, and criminal law.

Before doing so, let me share some of my opinions, and those of most of my Center colleagues, on this sensitive topic. First, as the title of our publication suggests, we fervently believe that any state response to this problem demands a well coordinated, multisystem effort. Second, the first response must be a public health one; without understanding the treatment and prevention resources that are available and that work, the more punitive criminal and child welfare interventions will be viewed out of context. Third, the constitutionality of state intervention in these cases, especially during the prenatal stage, is remarkably undecided. No court has yet squarely addressed most of the constitutional issues raised by these cases in the specific context of prenatal substance abuse. Thus we simply do not know, and probably can not predict with any degree of certainty, how the courts will decide constitutional challenges in the future. Finally, many of our existing laws, if properly used, are adequate to address child welfare and juvenile court procedures, and that the greatest attention should be placed on assuring that these systems have the resources to effectively deal with these cases.

Public Health

It is today widely acknowledged that substance abuse by women of child bearing years is a significant problem, and that appropriate treatment programs for pregnant women and young mothers and infants are not sufficiently available. It is also recognized that primary prevention programs aimed at educating the public on the effects on fetal development of drinking, smoking cigarettes, and using drugs is ultimately the best way of reducing certain injuries to the child. In light of this, state legislatures are beginning to enact substance abuse prevention and treatment programs for pregnant women.

Primary prevention may involve relatively inexpensive, but potentially far reaching programs. It may range from education, for example 1989 Connecticut legislation requiring substance abuse prevention to be offered as part of health and safety instruction programs in public schools; to posting in liquor stores warning signs about the risk of alcohol related birth defects, as required in a 1989 Illinois law; to even, as 1988 New Hampshire legislation requires, distributing a brochure on fetal alcohol syndrome to couples applying for a marriage license.

Treating substance abusing pregnant women unfortunately is not so easy, and requires a major commitment by elected state officials and executives. But some states are beginning to do just this. For example, Illinois, in 1989, appropriated funds expressly for the purpose of developing a model program in Cook

County for the "care and treatment of addicted pregnant women, addicted mothers and their children." Washington State, in 1989, pumped significant new funds into its drug and alcohol treatment programs and, among other things, mandated first priority for receipt of these services to pregnant women and parents of young children. Similar priority language is now found in law or agency policies in California, Maryland, and other jurisdictions. Washington State has also provided funds specifically for a "continuum of treatment" for this population. By law, this includes inpatient programs capable of serving pregnant women and postpartum women and their infants; transition housing for these individuals; and outpatient or follow- up treatment which includes a child care component.

In neighboring Oregon, the state legislature last year called for a "holistic approach" to the problem of drug and alcohol using pregnant women by providing for "biological-physical" needs, such as detoxification, dietary, and obstetrical services; psychological needs; instrumental needs, such as child care, transportation and housing assistance; and educational needs. It created an advisory committee charged with developing plans to implement this approach. Rhode Island has taken a similar first step by establishing, last year, a special commission to study the current status of substance dependency treatment programs available to mothers and corresponding placement options available to young children of mothers who are substance dependent. Congress too must be acknowledged for recognizing the treatment needs of this population and by authorizing funding for model prevention, education, and treatment projects.

Civil commitment is a public health measure of last resort. Most states already allow for the civil commitment of drug and alcohol abusing individuals if other criteria, such as demonstrable dangerousness to self or others, are met. Thus states have not amended their civil commitment laws to signal out substance abusing pregnant women. The one exception is Minnesota, which in 1989 enacted the most sweeping state intervention law to date. It combines aspects of civil commitment and child protection intervention, depending upon the time of intervention.

Under the Minnesota law, a mandated child abuse reporter who "knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during pregnancy," must report this to the local welfare agency. Indeed the law even requires a treating physician to conduct a toxicology test of the pregnant woman under certain circumstance. The welfare agency must immediately assess the situation and offer services, such as referral for chemical dependency assessment and treatment and prenatal care. If the woman refuses or fails treatment, then the agency may initiate civil commitment proceedings. By treating this as a civil commitment and not a child protection case during the prenatal period, the state hopes to avoid constitutional challenges based on a pregnant woman's privacy and bodily integrity interests. In theory, the civil commitment may be based on a parens patriae ground, that is the woman is unable to care for herself or engage in behavior, such as seeking treatment, that would ameliorate her problem. In short, the commitment is for her benefit, and not for the benefit of the fetus.

While civil commitment is a possibility for substance abusing pregnant women, if they meet the substantive and procedural due process criteria, it, like any other form of coercive state intervention, is purely punitive in the absence of appropriate treatment. Indeed, experts in the civil commitment arena, including the 1977 President's Commission on Mental Health and the American Psychiatric Association concur that involuntary commitment is inappropriate where treatment that is likely to be effective is not available. In speaking with professionals from Minnesota, they agree that there are treatment

slots available for substance abusing pregnant women, although they admit not all of the programs are ideally suited for this population.

Child Welfare

Several states, such as Florida, Illinois, Indiana, Massachusetts, Minnesota, Oklahoma and Utah, have recently amended their child abuse laws to specifically address the issue of drug, and sometimes alcohol, use by pregnant women. Though too few to call a trend, the direction has been towards defining specific situations where a child abuse report must be made after birth. The circumstances which necessitate a report are either that a newborn manifests signs of being physically dependent or tests positive for a drug.

Opponents of such reporting raise the "slippery slope" argument. They assert that once you penalize prenatal drug use, other lawful activities potentially harmful to a fetus will be included. Thus a pregnant woman may face punishment for drinking liquor, smoking cigarettes, exercising, dieting, or for a host of other activities. Furthermore, since we do not know exactly what activities are harmful, they run the risk of being punished for conduct they had no reason to suspect. This is a serious concern and one which policy makers need be on guard for. It may not be insurmountable. State legislators have so far been careful in drawing lines. They have limited reporting to infants who test positive for or appear dependent on illegal drugs, or in some cases if they exhibit signs of fetal alcohol syndrome. This is usually done by cross referencing to the state's controlled substance law (which, incidentally, may not include marijuana). Furthermore, several states have qualified this by excluding drugs taken pursuant to a prescription or as part of chemical dependency treatment.

The only exception to date, where a woman may be punished for legal behavior, is in the area of alcohol abuse. Some states, such as Indiana, Nevada, and Utah include children born with manifestations of fetal alcohol syndrome in their child abuse or children in need of services laws. While this may be an opening towards penalizing other types of lawful conduct, it is important to note that it is now limited to an area where the relationship between drinking while pregnant and fetal harm is well documented and accepted.

Another thing to note about these new laws is that, in mandating a report based upon a "newborn" or "infant's" status, they do not apply to the prenatal period. By authorizing only post-birth intervention, these laws may skirt the constitutional objections. These laws also, except for Minnesota's, avoid the issue of mandating testing of newborns, even if a report is based on a positive toxicology test.

As previously mentioned, in Minnesota, once a child is born, this issue is treated as a child protection matter. The law requires a physician to administer "to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose prior to birth." The physician must report any positive result to the child protection agency. While other states do not address the testing issue, many commentators argue that the test, if done for the infant's medical care and treatment, is covered by general consent forms the mother signs upon admittance to the hospital. Others argue that if the report could lead to punitive sanctions against the mother, her informed consent to the test should be required. As with so much of this issue, there are no cases on point.

One of the many criticisms of drug testing is that, depending on the substance, it may not detect drugs that have not been "consumed" within a certain time period. For example, traces of crack cocaine will disappear from the body within 72 hours of its last use. The Minnesota law, partially in response to this, does not relieve the physician from reporting if the newborn's test is negative. If "other medical evidence of prenatal exposure to a controlled substance is present" the physician must still report.

A second criticism of testing newborns (and pregnant women) is the potential for discrimination. Where the test is left to the treating physician's discretion, the possibility for biases, even if unintentional, exist. For example, a hospital may develop a protocol for testing that looks at the pregnant woman's history of prenatal care. While this may indicate drug use, it is even more suggestive of her lack of financial resources to pay for such care. Due in part to this potential bias, and the lack of a universally acceptable profile of a drug abusing mother, the conditions which warrant a test are highly controversial. Not surprisingly, this has led to two opposing viewpoints: those favoring universal testing, and those opposing all testing. Further compounding this unintended biases are real biases. At least one study in Pinnellas County Florida has shown that, based upon positive toxicology screens, physicians disproportionately report minority women. While one study is far from conclusive, it is certainly consistent with other long held views about the public child welfare system. Other criticisms of testing cite its cost, inaccuracies, and inability to distinguish casual from chronic drug usage.

Before moving on from the subject of the child abuse reporting laws, an important issue should be addressed: do existing reporting laws that do not specifically mention drug dependent newborns cover this situation? To date, several courts, and at least two state attorney generals, have interpreted these laws to not apply to the prenatal period. These decisions are based upon literal interpretations of the child abuse reporting and juvenile court code statutes. In these laws, child abuse is typically defined by referring to injuries to "children." The courts have concluded that a fetus, for these purposes, is not a child, and thus it would be premature to report or assume court jurisdiction during this period. In support of this reasoning is the fact that state legislators, when they desire, have clearly extended rights and protection to fetuses, such as in the area of inheritance and wrongful death. However, and this is critical, none of these decisions have been based on constitutional grounds. And, in fact, some of these opinions have specifically conceded that the legislature "may choose to address this type of situation and design effective statutory authority." If and when this occurs, we may expect to see constitutional challenges which will force the court to weigh a woman's privacy interests against the state's compelling child protection interest.

Whether these general abuse and neglect laws apply once a child has been born is less clear, especially if the only known fact is that the child tested positive, or manifests some dependency on, a drug. This uncertainty was demonstrated in the recent study by the Inspector General's Office of the U.S. Department of Health and Human Services. In a study of 12 cities, a mixed response to this reporting question was received, ranging from mandatory reporting of these cases, to voluntary reporting of these cases, to not reporting these cases in the absence of other incriminating information. It should be noted that in two of the cities, Miami and Chicago, the state law mandates reporting based solely on drug dependency or a positive toxicology screen respectively.

Another way of looking at this question is by asking "what is the purpose of a child abuse report." If drug use by a pregnant woman raises a meaningful possibility of future harm to

the child, then a formal inquiry into this possibility seems warranted. This inquiry might look at a host of factors, most of which looks to the mother's current status and other circumstances, and not those while she was pregnant. They might include such questions as:

- o is the woman currently using drugs
- o is she cooperating with and undergoing treatment
- o are there older siblings and if so, have they been abused or neglected
- o are family and other support systems available to the mother
- o what are the health care needs of the child.

This inquiry does not necessarily have to be conducted by child protection workers. A legislature could assign this function to others, such as public health nurses or hospital social workers. And, indeed, communities such as Los Angeles have developed a multiagency response to this problem by teaming public health and child welfare professionals to investigate and assess these cases.

The objection by some to mandatory reporting based solely on evidence of prenatal drug exposure (a reporting per se ground) is that it presupposes, to a certain degree, that women who drink or use drugs while pregnant are inherently dangerous to their children. Often sensational media stories, that report only horrific cases, contribute to this popular belief. Legislators should not be so fooled. Yes, many substance abusing women, due to their addiction and the affects of drugs on their parenting ability, are dangerous to their children. The child protection system should intervene accordingly. But what about, for example, the mandated reporter who knows that the mother does not pose a current risk to the child because she has been drug free ever since discovering she was pregnant. Should legislators, in taking an absolutist approach, include such a woman in the reporting scheme? If so, they must assure that these cases will be handled, and resolved, expeditiously.

Where this concern comes to the forefront is when evidence of drug dependency or fetal alcohol syndrome by a newborn constitutes a prima facie case of abuse or neglect. In Illinois, by statute, this is the case. This shifts the burden to the mother to prove that the child is not at future risk of harm. Such shifts will almost inevitably elongate the process and increase the chances of "innocent" women being ensnared in the child protection system.

In the absence of a statute, when courts have had to decide whether a drug test or drug dependency constitute prima facie evidence of abuse, there has been a split of opinion. The majority tend to view these factors as only probative of future abuse, but not conclusive. As one family court judge found, a woman's prenatal drug use alone does not establish her inability to parent anymore than evidence that a parent had used drugs at some other point in his or her life establishes that he or she is presently unfit to parent. In these cases, the court will admit evidence of a mother's drug use while pregnant, even though they could not entertain jurisdiction during the time of her pregnancy. To sustain an abuse charge, however, the mother's prenatal conduct must be connected to a post-birth risk of harm. Notwithstanding some case law to the contrary, many persons report that, as a practical matter, child protection agencies will remove children and sustain court jurisdiction solely on this evidence.

The factors a court may consider, in addition to this drug use, are similar to what would be looked to in an investigation. In Los Angeles, the Superior Court Juvenile Department a few months ago drafted decision making protocols for drug-related dependency cases. Among the factors listed for judicial consideration in deciding whether, at the detention hearing, it

would be safe to return the child home are: presence of family support, willingness of a parent to participate in drug rehabilitation programs and testing, home environment, parent's drug history, and child's medical condition.

Assuming the state has found abuse or neglect, based in part on a woman's prenatal drug use, these cases should be handled like any other in the child welfare system. This means the requirements of the federal Adoption Assistance and Child Welfare Act must be heeded, including 1) reasonable efforts determinations before a child is removed from home, 2) case plans developed where a child has been removed, and 3) periodic reviews of the case.

Placed in the context of parental substance abuse related cases, these requirements raise several recurring questions: first, when is it safe to leave a child in a household with a drug abusing mother; second, what services are available and work with these mothers, both family based and out-of-home; and third, how much time do we give the mother to improve? While these questions must often be decided in a legal setting, they are not legal questions. The answers to these will depend upon the drug status of the mother, and, more importantly, what treatment and services the community has to offer. For example, if the best treatment for a cocaine-abusing mother is long term residential drug care augmented by other social services such as job training and followed by housing assistance, and if the community can not offer these services, then early termination of parental rights might be what is fairest for the child, if not for the mother.

As mentioned in the public health section, coercive state intervention must be in concert with treatment. Any state that elects to include this population in its child protective case load should first attempt to deal with it as a public health issue before a child is even born. For example, in Illinois, which now mandates reporting of drug dependent newborns, the state legislature has also amended the state medicaid act requiring medical and health care providers to refer pregnant women who are being provided prenatal services and are suspected of drug abuse to a local substance abuse treatment provider. Costs of this treatment will be covered by the medicaid program. Additionally, the law specifies that the state will not sanction the recipient solely on the bases of her substance abuse.

When voluntary treatment fails, and child protection steps in, treatment must still be addressed. In Oklahoma, this need was emphasized in 1989 legislation that specified that placement plans submitted to the court, in cases of a child born "in a condition of dependence on a controlled substance," may require the mother and any other adult living in the household who is drug dependent to complete a treatment program prior to the child's return home. It also authorizes monthly testing for substance abuse for a one year period following the child's return.

Once child protection has entered a case, it must work closely with the treatment community, both to assess the case needs and assure adequate resources are made available. This cooperative approach is not unique to this population; many states are already seeking to enhance interagency coordination, case management, and funding, particularly in providing early intervention services for at-risk infants and toddlers. With this population some of the treatment-related problems that the child welfare system must address include: development of long-term residential treatment programs that will serve the mother and child (the 28-day rehabilitation program isn't sufficient); recruitment, payment, and training to foster parents for the care of drug-exposed, often medically fragile children; development of appropriate and intensive family-based services for this population; and assuring that when out-of-home placement is necessary for medically needy children, that suitable, least

restrictive, "family-like" settings are accessible. Again, these are not so much legal issues as requiring a commitment to fund treatment programs and related services. A few encouraging legislative efforts in this regard have been seen. For example, California in 1989 appropriated funds for demonstration projects to support special foster care services for HIV and drug exposed newborns, to include special training for foster parents and coordination of funding and services. Congress similarly, through the Abandoned Infants Assistance Act of 1988, has sought to promote better case plans, more comprehensive services, and better trained care givers. Michigan has diverted some foster care funds to support family-based services for this population.

Not all families can be "saved." The laws in most states, on their face, contemplate that no child should be allowed to linger in foster care, and that if necessary, parental rights should be terminated and the child freed for adoption. Existing state termination laws already cover this population. If there is a problem, it may less with what the law says, as with attitudes and practices.

Termination of parental rights in these cases may often be based on one of two grounds: parental incapacity or abandonment. Most states have a parental incapacity ground for termination of parental rights. Under this, a parent's rights may be terminated if due to a severe mental or physical condition, often specifically including excessive use of alcohol or a controlled substance, the parent is incapable of caring for the child. Many states require expert testimony to establish the disability, connect it to parental failures, and show that it will not improve over time and with treatment or services. In some states it may not even be necessary to delay termination proceedings while rehabilitation efforts are attempted, if the evidence shows that such efforts would be futile.

A related ground for termination would be the failure of the parent to remedy the condition (or incapacity) which caused the child's removal. If substance abuse was identified as a major problem and the case plan set forth appropriate treatment, the parents failure in or refusal of treatment could sustain a termination action. This is an area where child welfare agency practices are critical. If the written case plan is deficient, or if the agency does not take appropriate steps to support it, efforts to terminate parental rights may be defeated or delayed.

This ground also presumes a period of time to try to remedy the problem. While some people assume, given the strong preference for parental rights, that this may mean several years, this in fact is not the case. Most state statutes, when they have a minimal time requirement, limit it to a year, and some impose no predetermined time. Some laws even, depending on the circumstance, require no time to pass before a termination action may commence. For example, in 1989 Oregon amended its termination laws to allow, in exceptional cases if in the child's best interest, a termination action without first making services available to the parent. One of the statutorily enumerated factors the court may consider in determining parental unfitness is whether the parent is "addictive or habitually use[s] intoxicating liquors or controlled substances to the extent that parental ability has been substantially impaired."

Finally, there is the ground of abandonment. This is especially significant with "boarder babies" who are deserted by their mothers at birth. Abandonment is a common ground to terminate parental rights, but it is hard to generalize its applicability. The ease at which boarder babies may have their parental rights terminated will depend on several factors that differ by state law. These include whether intermittent, infrequent contact of the parent will defeat a case for abandonment, whether an intent to abandon must be proven, and how much time must elapse to establish a case.

In recent years some states have moved towards expediting termination of parental rights based on abandonment by, for example, shorting the period of time. Whereas one or two year periods of abandonment were once the norm, many states, such as Montana, N.C., N.Y., Neb., and Utah now only require six months, and some only three months. Some states, recognizing that infants are particularly harmed by instability and a denial of a chance to bond with a permanent caretaker have shortened the time period of abandonment for newborns or infants under six months old. For example, in Delaware, the minimal abandonment time period of a newborn is 90 days, compared to six months for an older child. A few states have eliminated any time requirement in exceptional cases. For example, Connecticut courts may terminate parental rights where they find "from the totality of the circumstances surrounding the child that such a waiver is necessary to promote the best interest of the child." Again agency practices, as much as any thing else, may needlessly delay terminations on this ground. For example, the agency may not satisfy diligent search efforts to locate the missing parent. A lack of agency resources may also contribute to delays. Yesterday's Washington Post article on the shortage of attorneys representing the District of Columbia in abuse and neglect matters demonstrates how inadequate resources and insufficient staffing may wreck havoc in any jurisdiction.

None of this is to suggest that the child welfare laws are perfectly adequate today. Indeed, there may be some real legal impediments to serving these cases. For example, states which allow abandonment claims to be defeated by the parent's sporadic contact with the child may make this ground difficult to prove. Or access to critical information in a termination proceeding may be blocked where federal and state drug and alcohol treatment laws preserve confidentiality. Or a juvenile court, in an abuse action, may lack jurisdiction to order a drug assessment of a parent. Many of these issues can be addressed legislatively, but many more can be dealt with by dealing with educational needs of involved professionals. Before legislative bodies propose wide sweeping state intervention laws, they would be well advised to assess their current laws and how they are being used. They be surprised to discover that with some fine tuning, a little education, and a financial commitment to treatment, the problem can be addressed.

Criminal Law

Finally, we come to the most controversial form of intervention, criminal prosecution. This approach has been tried at both the prenatal and postnatal stages, under a variety of theories.

Prosecutions based solely on evidence of a pregnant woman's drug use have been mostly unsuccessful. Yet it seems to be an increasingly popular approach and its history is not over. One of the first attempts at prosecuting a woman for her prenatal abuse occurred in San Diego in 1986 and ended when the trial court found that the state law did not impose a duty to care for a fetus on a pregnant woman. In other cases, proof problems may defeat prosecutions. For example, in a recent Wyoming case, a pregnant woman was prosecuted for excessive drinking while she was under a court order to abstain. The case was dismissed because the state could not meet its burden of proving that the fetus was actually being injured by the drinking. In Rockford Ill., a grand jury refused to indict a woman for involuntary manslaughter after her two-day-old baby died of severe oxygen deprivation. The prosecutor had attributed her death to cocaine that had been detected in her urine, but the grand jury failed to find the connection.

Since most states do not currently recognize criminal maternal fetal abuse, prosecutors have resorted to "creative" charging. In the first and so far only successful prosecution nationally, a Florida judge convicted a women of delivering a

controlled substance to her twin children via the umbilical cord at birth. Thus, in theory, the prosecution was based upon a post-birth criminal action. On sentencing, the judge gave her 15 years probation, which included one year of strict supervision by probation officers during her drug rehabilitation program, monthly random drug testing for one year, educational and vocational training, and an intensive prenatal care program if she ever becomes pregnant again.

A second route taken by prosecutors in these cases involve pregnant women already in the criminal justice system for unrelated reasons. In these cases, pregnant women who would normally receive probation or be released on bail prior to trial are being imprisoned to keep them "drug free." (A dubious place to be for this purpose.) The Brenda Vaughan case in the District of Columbia is probably the best known of these cases because the judge openly admitted that his motive, in sentencing her to four months in jail as a first time offender convicted of passing bad checks, was to keep her off drugs during the remainder of her pregnancy.

A third tactic is to charge a mother with criminal neglect if her baby is born with evidence of drug exposure. This is the criminal counterpart to civil abuse prosecutions which are brought after birth, but predicated on pre-birth conduct. To date, no court opinions or judgments on the legality of such charges have been rendered.

Regardless of the charge or the time it is brought, these criminal actions have engendered the most heated debate over the use of coercive state intervention. On one side are prosecutors who, while often expressing distaste for such prosecutions, see them as the necessary leverage to get women into treatment and to send a message to the community. They argue that, from experience with other drug offenders, most will not voluntarily participate in treatment, but will do so when threatened with jail. On the other side are those who fear that criminal sanctions against pregnant women will cause them to shun prenatal health care visits and hospital deliveries, and even encourage abortions. They also dispute whether the "coerced" treatment approach works with this population. Such views have been expressed by a wide segment of society, like the Honorable John L. Henning, Supervising Judge of the Juvenile Dependency Court for Los Angeles County, who in urging the California legislature to not impose such sanctions, stated: "there is a clear handicap in terms of getting women to go for prenatal care, because then they would be concerned about the fact that they would be criminally prosecuted if they were to come forward, and also whether they would deliver children in hospitals, or whether or not they would choose to have their children someplace outside of the hospital setting.

Criminal prosecution also evokes the strongest debate over the fairness and constitutionality of punishing a woman for her conduct while pregnant. The fairness issue can be framed as a due process question: is it fair to penalize women when you haven't offered them treatment. Put more bluntly, some call such prosecutions "mean spirited." The alleged constitutional defects range from violations of a woman's fundamental right of procreation, to violations of due process when prosecutions are based on use of legal substances, to equal protection challenges that men, whose drug-damaged semen may cause fetal injury, are not being prosecuted. Legislators, advocates, and prosecutors are left to grapple with these issues as there has yet to be definitive appellate court decisions on these constitutional challenges. Indeed, the absence of clear guidance from appellate courts makes any attempt by the state to coercively intervene in the course of a woman's pregnancy, or punish a woman solely on the basis of prenatal conduct, suspect.

Conclusion -- Lessons from Washington State

In closing, I'd like to share with you the results of a survey we conducted late last year in Washington State. At the invitation of the state's Division of Alcohol and Substance Abuse, we interviewed nearly 50 persons from across the state. These persons represented a cross section of professionals involved with the issue of pregnant women substance abusers, including physicians, psychiatrists, chemical dependency experts, child welfare professionals, judges and prosecutors. The survey's purpose was to determine professional reaction to the new comprehensive treatment law mentioned earlier in this testimony, and whether there was any desire to move towards more punitive sanctions. Perhaps the most remarkable finding was the degree of consensus among the issues we explored, yielding the following predominant opinions:

1. The problem of drug and alcohol use by pregnant women should be treated mainly as a public health issue with the goal of bringing healthy babies to term deliveries. Opinions regarding drug testing were based on health concerns: those in favor of more testing did so as a health benefit to the infant; those opposed cited the fear that women would avoid prenatal health services.

2. The strong treatment laws recently enacted should be given a chance to work.

3 Current civil child abuse and neglect laws that make no reference to drug exposed newborns adequately address this issue: there is no need to enact special laws for this population to assure reporting or court jurisdiction in appropriate cases.

4. Pregnant drug and alcohol abusing women should not be penalized as criminals. This may (still undecided) pose constitutional difficulties and, more importantly, deter prenatal health care.

5. Involuntary civil commitment laws should be extended to include addicted pregnant women (currently available only to alcohol abusers) <u>provided that</u> it is used only after appropriate voluntary treatment opportunities have failed.

6. More funding, for medical and social service needs of these women and children, is needed.

Acting Chairman DOWNEY. Well, I have listened to a lot of testimony in the 16 years that I have been a Member of Congress, and I must admit that I have never listened to anything more powerful than yours, Ms. Clay, and Ms. Denton's and Mr. Horowitz' and that of Dr. Zuckerman.

What strikes me initially is the fact that this is not rocket science, that you have figured out pretty much what works and what does not work. And the question is of coordination, and a recognition that punitive behavior here on the part of the State is likely to exacerbate the problem as opposed to ameliorate it.

Let me ask you a couple of questions about this, and you help me to think this through.

Let's assume that the children in Minnesota and Illinois and elsewhere are important to us as a nation, and that leaving them simply to whether the State has a good program or not is dissatisfying to me as a national legislator. What tools could we bring, what tools could the Congress bring to bear, to help the States that want to do a good job, proliferate programs like DEMAND, for instance?

You mentioned that you need facilities. Well, how do we help you get the facilities? Do we demand that of the States? There will be my colleagues who will say, well, before I provide several billions of Federal dollars, I want to know that the States are as interested in doing this as well. Is it appropriate for us to demand from the States that they tax their citizens as well to deal with State problems? How do we coordinate whether or not this is a Federal and State program? What should be the appropriate level? What would be the legislative mechanism? Would title XX of the Social Security Act, which provides us broad latitude, be a way to provide this?

I am assuming that we have universal agreement. And again, that is probably not true, but this is a public health catastrophe of the first order. If this was an epidemic occurring in middle-class neighborhoods, you would bet that we would be jumping up and down to solve this problem. But a lot of this problem is in the inner city. A lot of it occurs to black people and not to white people. And therefore, for some reason, it is not of the concern that it should be to all of us as Americans. But, it is happening to Americans, and that is the way we need to think about it and deal with it.

Ms. Clay, tell me about just the Federal and State role for a minute. How would you propose that we proliferate the program that you have in your own State as an example?

Ms. CLAY. The DEMAND program started out as a pilot program about 2½ years ago with a grant. We are now being funded by the State. We have a 3-year funding. They gave us the startup funds, and so we have these funds available for 3 years. At the end of this 3 years, we are not sure where we are going to get the funds from. Hopefully, they will allocate money and continue the program. We are just not sure.

In terms of what needs to happen or where the dollars need to come from, I am not sure. I know they need to come from the State. If the Federal Government can mandate the State or the legislation should do something, fine. In my mind I keep thinking,

well, you either free up some money to do something now or you are going to free up some money to do something later.

Acting Chairman DOWNEY. Sure. We will have to free it up to put them in jail because there will be so many crimes of violence.

Ms. CLAY. You are exactly right.

One of the things in terms of the State and the need and in terms of the clients that we are seeing, Turning Point is a culturally specific program which means that our services are geared toward African American women. Mrs. Denton talked about 85 percent of her population being African American women. We are probably seeing about 95 percent being African American women. The two hospitals that they pulled most of these statistics from service African American women, and I would say that 90 to 95 percent of child protection cases in Minnesota are children of African American women. And that is real scary. The women are now surpassing men in their use of crack cocaine in the State of Minnesota.

I do not know where the dollars should come from. I really do not, but I know we need the dollars bad.

Acting Chairman DOWNEY. Ms. Denton, help me with that for a minute. You see the Federal program. You deal with the State programs. You get some Federal assistance from IV–B, IV–A and title XX and other things. If we wanted to say there should be treatment and prevention, if we wanted to start with that for everyone who wants it, let's assume, that would be a good starting place. Right?

Ms. DENTON. I would see a continuation of matching funds. I do not feel that any one government entity should pay the whole freight. I would also see on the Federal level a requirement—and I do not know how you do this, but a requirement that there be a systems integration on the Federal level, just as we are working it on local levels, because you have housing grants that come to municipalities through HUD. You have our moneys that come through Social Security and title IV–E, IV–B, all of that. Somehow it needs to be seen as a total impact on the problem.

And in Illinois, what we are doing now is looking at a combination of reimbursement moneys and GRF in creating new integrated services within our communities. However, when the Federal Register comes out, the Department of Children and Family Services will probably not be able to apply for a HUD grant. There needs to be a way on the Federal level also of integrating packages that say we want our society to look different. And the only way we can do that is to see that this black impoverished woman is a member of this society and has a right for integrated services.

Acting Chairman DOWNEY. Mr. Horowitz.

Mr. HOROWITZ. On the funding issue, I think there are some vehicles that Congress has initiated, and one should consider the full funding of them, such as the Abandoned Infant Act, which began in response to pediatric HIV, but has shifted from the pediatric HIV problem to just the general problem of children born substance abuse exposed.

Second, I have been told by people in the alcohol and drug community, of which I am not as familiar with the entitlement programs, that there are some programs that do go to States. They

have set-aside moneys for pregnant women, for women and children, that simply are not really being used at the States the way Congress may have intended. You may need to look at how are States using the money which you are already given.

Third, I do think title XX and the other existing programs may be a means. There is always going to be a need for money. And I cannot tell you 12 percent State/88 percent Federal. I can only tell you that there is an incredible need for more money.

I would like to tell you a few other things that I was jotting down that I think that this committee could do. You have just heard of the wonderful program in Minnesota. I serendipitously hear of other such small programs. People need to know about these programs. The Federal Government always has a leadership role in dissemination of information on programs that work because I have been struck by how many programs that really started on a shoestring, without State money, without Federal money, but a lot of hard work, and have made it. I think this information needs to be shared.

I think postadoption disruption and the adoption issue is something that the committee may want to look at. What are the postadoption services we can give to these families who do adopt these children? I think we need to know more about the needs of those families, and there may be more of a Federal role.

I think Dr. Zuckerman gave us an insight about some of the basic informational needs we have. What does happen 5 years later to these families in the child welfare system? I am not talking about now funding all the research on developmental problems of children 5 years later. We are starting to see that, but we are not seeing the child welfare funded research along that line.

And finally, it is something I avoided from my remarks, but I am sure it is something that this subcommittee has heard of many times and I think should take a look at. And that is, is this problem driving this idea of a return of the orphanages? And if so, what does that mean to 96–272, how do you feel about that? What does that do to reasonable efforts, et cetera?

Acting Chairman DOWNEY. Now, the subcommittee, in answer to your inquiry, has seen several of the points of light, the thousand or more or million or more, that are out there in the country. And it is our collective frustration that we cannot have a big focus beam from us into the States to help you some more. But we are going to carefully consider what you said here today and take it back to our chairman, who I know is sympathetic and concerned about this. Our subcommittee has jurisdiction over title XX, which we enjoy using to deliver a whole variety of services and Federal dollars.

Mr. Shaw.

Mr. SHAW. Thank you, Mr. Chairman.

This has been certainly a full day and a very, very full panel.

Acting Chairman DOWNEY. It is only half over. [Laughter.]

Mr. SHAW. I think any one of you could have been the subject or a hearing by yourself, and perhaps we should return to that after we have digested what we have learned here today.

For about 9 years, I was on the Select Committee on Narcotics Abuse and Control before I came on the Ways and Means Commit-

tee. We held a meeting down at Broward General Hospital in my district in Fort Lauderdale, Florida. At that time—this was about 3 years ago—it became apparent through the witnesses that in Broward County and, indeed, perhaps throughout the country, that treatment was not available to pregnant women because of the tremendous liability involved in having them under your care and then delivering the baby that could cost up to $100,000 a year just to take care of in the worst scenario.

As a result of that, in the 1988 drug and crime package that passed in Congress, we inserted a provision that moneys had to be available for treating pregnant women. These are the Federal moneys that are going out.

Particularly Ms. Denton and Ms. Clay, are you seeing that there are still problems with treatment funds out of the Federal funds for pregnant women or has that sort of taken care of itself? Ms. Clay.

Ms. CLAY. I think that there is still a problem.

Mr. SHAW. Are you seeing that, Ms. Denton.

Ms. DENTON. I do not know how the moneys are gotten to communities. What I do know is that there is still a paucity of resources. For instance, in juvenile court we might have a mom coming in where there are other children that are known for substance abuse and we cannot get her linked to services to protect her baby in utero. Whether that is a problem of getting the money out there or not enough money to get out there, I just do not know, and probably someone from our health departments and public aid could speak to that much better than I.

Ms. CLAY. I think it is not having enough money to get out there. It just feels like there is not enough money to get to the agencies to reach the people. That is what it feels like.

Mr. SHAW. That is a countrywide problem. We certainly have that in Fort Lauderdale. I know Charlie Rangel from the Harlem area of New York has just complained that people in New York are ready for treatment, and then they are told they have to wait 6 months. You may not ever see them again.

Ms. CLAY. That is right.

Mr. SHAW. And you have to get to them at the right time. We really have neglected the area of treatment.

I would like just to comment briefly on some of the other points that were made by several of the witnesses, particularly Dr. Zuckerman.

We do not want to come down so hard on the condition of the baby so that we will find that they are not adoptable. This would certainly be a tragedy. But we must also be careful in our balances so that we do not underestimate the damage that the mother can do with the use of drugs, including alcohol, during pregnancy. Sometimes it is difficult to find out exactly where you come down on the side of being responsible in your comments, but this is something that could have a tremendously negative impact on the whole subject.

I was over in East Berlin in December, and in speaking to the caretaker head of the Government of East Germany, drug abuse was one of the questions, one of the main concerns, that they had. And I think that it is a great concern. With their new freedoms,

open borders and things of that nature, they may soon find the drug problem coming their way because one of the things that brings it into our country is that we are such a free society. But it is going to have a very negative impact on the future of this country.

The question is what can we in Government do to cut our losses short and to help the victims. There is no more ultimate victim of crime than a cocaine baby.

Thank you, Mr. Chairman.

Acting Chairman DOWNEY. Thank you.

Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Horowitz indicated that prevention would be a suitable goal for us as a society, and I would just like to open it and ask Ms. Denton. What is it that the people who are using drugs and demanding the services that you have—what life experiences and equipment and tools do they lack, or what have they experienced that led them to their situation.

Ms. DENTON. That is a very complicated question and also a very simple one in a way.

The families are poor. They are black. They often cannot read or write at an acceptable level. They left school at a very early age either to work to bring home a pittance or to care for their babies that were born at the age of 13 or 14 or to hustle in order to survive.

I was very impressed. In March we had at the Child Welfare League a chemical dependency symposium. And I referenced to Dr. Peter Bell not too long ago. He talked about the difference in substance misuse in my America, middle-class professional, white America, versus the substance abuse in impoverished black America.

He said in white America, as we begin to use a substance, we begin to experience an inability to go to work, a drain on family finances, family disintegration, whereas in black America, if you do not have a job and if you do not have good housing, the first abuse is not the intake of the drug, it is the marketing of the drug. So, you begin to feel a positive impact on your family and your life instead of a negative impact. In my society, if there is a problem, I get help when it begins to pinch my pocketbook. In the impoverished black society, they begin to get help due to legal intervention. And I think we have to think about—that is where all of that that is so complicated seemed so clear when he mentioned that.

And I think we also have to think about the drain on the society of good brain power. We have children. I have spent 20 years of my life, most of it working with adolescents, disenfranchised youngsters. And as they have had an opportunity, some of them are, indeed, capable of being Rhodes scholars. We write off a segment of our society, and then we wonder why there is talk about Social Security collapsing. We blame Japan for our problems in industry when we have these thousands of children.

This year Illinois will top 20,000 children in out of home care. They came to us because of lack of opportunity and abuse. Not many of those children are middle, upper middle class children who end up in out of home care in Illinois.

So, I think prevention goes back to housing, education, equal opportunity. To look at prevention of drugs is really much more an interventive step instead of a preventive step.

Mr. COYNE. Thank you.

Does anyone else care to comment?

[No response.]

Acting Chairman DOWNEY. Well, let me just say that as we talk about additional resources—and all of us know how tough that is with the day-to-day problems of attempting to deal with the Federal budget and its enormous deficit—that one of the lessons here and what we saw today at D.C. General is that we are already incurring absurd costs. An 8-month stay by a child in an intensive care unit who is born premature has already cost society more than your program. If you save one or two children from an intensive care unit, you have already saved the State a fortune.

Ms. CLAY. That is right.

Acting Chairman DOWNEY. Not to mention all of the other enormous personal suffering and anguish that the mother and the child and the other people who are involved in this process must go through.

Well, this has been a very sobering morning. Thank you very, very much for your excellent testimony.

The subcommittee is adjourned.

[Whereupon, at 12:57 p.m., the hearing adjourned.]

[Submissions for the record follow:]

STATEMENT OF
MARTHA KENDRICK KETTMER
PRESIDENT, THE JUNIOR LEAGUE OF
THE CITY OF WASHINGTON, INC.

Submitted to

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES
UNITED STATES HOUSE OF REPRESENTATIVES

April 16, 1990

Mr. Chairman, Members of the Subcommittee, I am Martha Kendrick Kettmer, President of the Junior League of the City of Washington, Inc. The Junior League is an international organization of women committed to promoting volunteerism and to improving the community through the effective action and leadership of trained volunteers. On behalf of the membership I am pleased to submit this testimony to the Subcommittee on Human Resources, Committee of Ways and Means, in conjunction with site visits and hearings held on the impact of crack cocaine on the child welfare system. I would first like to commend the Honorable Thomas J. Downey (D.-NY), Acting Chairman of the Committee and his colleagues, Congressman Byron L. Dorgan (D.-ND), Congressman F. Clay Shaw, Jr. (R.-FL) and Congressman William J. Coyne (D.-PA) for their foresight in convening public hearings on such a critical issue.

The Junior League of Washington has become increasingly concerned about the devastating developmental impact of drugs on infants and young children. The issues are fairly straightforward and simple: Either we pay now by providing funding for continued research on the impact of crack cocaine on infants' physical and emotional development, or we pay later by having a generation of children who cannot meet their full potential because of serious birth anomalies. Either we pay now by providing further tax breaks for those who provide foster care or adopt these children, or we pay later as a society with socially dysfunctional individuals unable to contribute to our nation's growth. Either we pay now by encouraging collaborative projects specifically designed to remove the child from a hospital setting, or we pay later by returning to the days of orphanages when children were throwaways because no one wanted them.

The Junior League of Washington's membership exceeds 2700 women, 85% of whom work outside the home -- approximately 1700 in the District of Columbia alone. Fifty percent (50%) of these women are mothers of young children. As a practicing attorney with three children under the age of eight, like other members of my organization, I am extremely concerned about the impact of drug abuse on children generally, and the specific issues facing our community.

The Junior League of Washington's commitment to issues affecting women and children is long-standing. Throughout our history, over $3 million has been donated to community projects in the Washington Metropolitan area, $1 million of this total since 1985 alone. For the current 1989-90 fiscal year, the Junior League of Washington will contribute over $305,000 for direct community funding in our two focus areas: "Youth at Risk" and "Women in Crisis." Many of the League's estimated 250,000 annual volunteer hours are devoted to the care of children and the support of women experiencing some type of crisis, whether it is homelessness, drug abuse, AIDS, or domestic violence.

As President of a membership that is acutely aware of the impact of crack cocaine on infants, I would like to discuss three initiatives of the Junior League of Washington undertaken to tackle a symptom of the increased abuse of crack cocaine: specifically, "boarder babies."

First, in March 1990, our membership voted to commit $50,000 to a "boarder babies" project in a collaborative effort with D.C. General Hospital and the Coalition for 100 Black Women. This Junior League-initiated project, in a pivotal public hospital setting, has four goals:

1) To provide infant advocates who will serve as volunteers with expertise in various professions assisting with the placement of babies either in foster care or through adoption;

2) To develop comprehensive educational programs in health and parenting targeted for prenatal and post-partum substance abusers;

3) In conjunction with the Coalition of 100 Black Women, to create a hospital auxiliary structure designed to give long-term support for "boarder babies," including a development arm that benefits from both private and public financial support; and

4) To enroll pregnant substance abusers in a prenatal program that teaches the physical, psychological and social effects of drugs on the mother and fetus, as well as to establish a mentoring relationship to help women overcome the sometimes overwhelming duties involved with parenting, complicated because of substance abuse.

Second, the Junior League of Washington, through our Community Affairs Research Committee, has undertaken a needs assessment of area hospitals to ascertain the extent of the "boarder baby" problem, the specific needs facing these institutions, and the supports other community organizations could mobilize to assist in addressing the problem. Once this needs assessment is completed, the Junior League of Washington intends to disseminate the findings. We also anticipate that these results will shape our future organizational commitments in this area.

Third, next month the Junior League of Washington will release a major public education and advocacy initiative entitled Washington's Child. The first prong of this initiative is a publication that graphically and succinctly will convey the horrible plight facing children and their families living in the District of Columbia, through photos and demographic data. In a recently released study conducted by the non-profit Center for the Study of Social Policy in 1987, the District of Columbia ranked near the bottom on children's well-being issues, defined as health, educational attainment and the general welfare of children. So horrendous do we perceive the affects of drug abuse on children and their general well-being, that this community education and awareness publication devotes an entire section to drug abuse and children. The second prong of this initiative involves formation of a collaboration of committed community-based organizations with a unified "children's action agenda" and determination to increase business and professional commitment and mobilize pressure on public policymakers to place children higher on the legislative and resource allocation agenda.

The Junior League of Washington believes that by committing both our money and our trained volunteers toward tackling the social and economic challenges presented by this one difficult drug abuse issue, we will directly impact the problem and better the quality of life for Washington, D.C. children. I want to underscore the high priority we will be giving to the prenatal education efforts -- until we are effective in direct intervention focused on prevention, we will continue to face long-term problems in the drug abuse area.

We must reduce the number of infants abandoned in D.C. General Hospital, and other hospitals in the metropolitan area, and provide the necessary intervention for mothers who are in

crisis and perceive abandonment of their child as their only alternative. Moreover, we must resolve to tackle the myriad of complicated legal issues raised by the "boarder baby" problem including, but not limited to, availability of these children for permanent adoption and termination of parental rights.

I have alluded to the social costs of "boarder babies" and the crack epidemic. Sustained residence in a hospital nursery serves no one -- not the baby, not the hospital's financial resources or staff, or society. Some research suggests the longer babies remain in a hospital setting, despite good intentions of volunteers and staff, the more withdrawn these children become. Many health and social welfare professionals are convinced the longer babies are in hospital settings, the more likely that they will become developmentally delayed and the greater the long-term risk of their inability to relate to people in socially acceptable ways. A baby needs space to explore the world around him or her. Hospitals are an inappropriate and far too expensive environment from which to demand the developmental and social nurturance equally crucial to these children's physical development.

Hospital administrators also report enormous lengths of stay and severe economic implications for their institutions. Often they are not able to recoup the financial outlay because these children lack medical insurance. At D.C. General Hospital alone, the average cost per case during a thirteen month period was $55,526 or $446 per day. Surely we can reduce these costs -- both economic and social -- by providing a system that quickly moves the baby out of the hospital and, ultimately, into a permanent home. The League sees this as one of the primary purposes of our voluntary efforts.

In conclusion, our objectives in the short-term are to begin to raise our community's consciousness and to develop model programs which will tackle aspects of the infant mortality crisis, like the D.C. General "boarder baby" project, while at the same time improving the overall health status of babies born to chemically-dependent mothers.

On behalf of the Junior League of Washington, again I thank the Subcommittee on Human Resources for the opportunity to submit this testimony. Many have referred to the current drug abuse crisis as a "war." "To the victor go the spoils of war." We must ensure that these "boarder babies" are not a part of such spoils. The victory must come from involvement of private sector initiatives determined to intervene effectively to address this critical community problem. Thank you.

APRIL 16, 1990

TESTIMONY SUBCOMMITTEE ON HUMAN RESOURCES,
U.S. HOUSE OF REPRESENTATIVES
ON THE IMPACT OF CRACK COCAINE ON
THE CHILD WELFARE SYSTEM

HONORABLE REPRESENTATIVE DOWNEY, COMMITTEE MEMBERS:

THANK YOU FOR THIS OPPORTUNITY TO PROVIDE WRITTEN TESTIMONY ON THIS IMPORTANT SUBJECT. AS DIRECTOR OF THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES, I AM WELL AWARE OF AND SHARE YOUR CONCERN FOR THE HIGH HUMAN AND FINANCIAL COST SURROUNDING COCAINE AND PARTICULARLY "CRACK" ADDICTED INFANTS AND MOTHERS.

INTRODUCTION

THE DEPARTMENT'S DRUG ABUSE PROGRAM OFFICE IS RESPONSIBLE FOR THE ADMINISTRATION OF A COMPREHENSIVE SYSTEM OF DRUG ABUSE PREVENTION AND TREATMENT SERVICES USING FEDERAL, STATE, AND COUNTY FUNDING. THESE FUNDS TOTAL APPROXIMATELY $44 MILLION IN SERVICES CONTRACTED WITH 67 PRIVATE AGENCIES. THE SERVICES INCLUDE PRIMARY PREVENTION, EARLY INTERVENTION, OUTPATIENT, RESIDENTIAL, OUTPATIENT METHADONE DETOXIFICATION, OUTPATIENT METHADONE MAINTENANCE, RESIDENTIAL DETOXIFICATION AND OUTREACH.

BACKGROUND AND SIGNIFICANCE

PERINATAL SUBSTANCE ABUSE IS DRAMATICALLY INCREASING IN THE UNITED STATES. NATIONAL ESTIMATES NOW INDICATE THAT 11% OF LIVE BIRTHS ARE DRUG EXPOSED. (SHERMAN, P.24). CALIFORNIA INDICATES A MORE CONSERVATIVE ESTIMATE OF 2-5% (10,000-25,000 IN 1988), (CALIFORNIA LEGISLATIVE ANALYST REPORT, P.252). IN LOS ANGELES COUNTY, THERE WERE 915 DOCUMENTED CASES OF NEONATAL DRUG EXPOSURE IN 1986, 1,888 IN 1987, AND AN ESTIMATED 3,000 IN 1988 (CAPP). AS COCAINE USE AMONG WOMEN HAS SOARED TO NEW HEIGHTS, STUDIES SHOW THAT SEVEN OUT OF TEN PREGNANT WOMEN WHO TEST POSITIVE FOR DRUGS USE COCAINE.

THIS INCREASE HAS CREATED GROWING CONCERN FOR THESE INFANTS. OF PRIMARY INTEREST IS THE SAFETY OF THE CHILD, ITS HEALTH, WELFARE AND FUTURE. OF LESSER CONCERN HAS BEEN THE MOTHER AND AN EMPHASIS ON MAINTAINING THE FAMILY UNIT AS A VIABLE AND HEALTHY ENVIRONMENT FOR ALL INVOLVED.

PROBLEMS ASSOCIATED WITH PERINATAL SUBSTANCE ABUSE

THE PROBLEMS OF PERINATAL SUBSTANCE ABUSE ARE MULTIPLE AND COMPLEX. INFANTS PRENATALLY EXPOSED TO DRUGS ARE AT RISK FOR NUMEROUS MEDICAL, DEVELOPMENTAL AND BEHAVIORAL PROBLEMS, BOTH SHORT AND LONG TERM. SHORT TERM PROBLEMS INCLUDE: PREMATURITY, LOW BIRTH WEIGHT, APNEA, STROKES, RESPIRATORY DISTRESS SYNDROME (RDS), GASTRO- INTESTINAL DISORDERS, IRRITABILITY AND SEIZURES. LONG TERM PROBLEMS INCLUDE: DEVELOPMENTAL DELAYS (PARTICULARLY LEARNING DISORDERS), POOR MOTOR COORDINATION, CONGENITAL DISORDERS, HYPERACTIVITY, AND SPEECH DIFFICULTIES. THESE INFANTS ARE ALSO AT HIGH RISK FOR SUDDEN INFANT DEATH SYNDROME (SIDS) AND AIDS.

THE CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES INDICATES THAT DRUG EXPOSED INFANTS ENROLLED IN REGIONAL CENTER PROGRAMS EXHIBIT LONG TERM PSYCHOLOGICAL AND SOCIAL PROBLEMS, INCLUDING POOR ATTACHMENT (CALIFORNIA LEGISLATIVE ANALYST REPORT, P.251).

A RECENT STUDY CONDUCTED BY THE NATIONAL INSTITUTE ON DRUG ABUSE FOUND THAT AS INFANTS EXPOSED TO CRACK COCAINE MOVE INTO EARLY ADULTHOOD THEY "HAVE SERIOUS DIFFICULTY RELATING TO THEIR WORLD, MAKING FRIENDS, PLAYING LIKE NORMAL CHILDREN. .'. ." (BLAKESLEE, NYT)

SCOPE AND INCIDENCE

THE ACTUAL NUMBER OF WOMEN WHO ARE ABUSING SUBSTANCES IS UNKNOWN. THE NATIONAL INSTITUTE ON DRUG ABUSE ESTIMATES THAT 15% OF WOMEN OF CHILD BEARING AGE ARE DRUG ABUSERS. IN LOS ANGELES COUNTY, A SURVEY RECENTLY CONDUCTED BY THE DEPARTMENT OF CHILDREN'S SERVICES AND THE LOS ANGELES COUNTY SUPERIOR COURTS INDICATED THAT APPROXIMATELY 15,600 WOMEN ARE COURT-REFERRED ON A ANNUAL BASIS TO DRUG COUNSELING AND TREATMENT FOR DRUG RELATED CHILD ABUSE AND/OR NEGLECT CASES.

IN A SURVEY COMPLETED BY THE NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION, 11% OF WOMEN GIVING BIRTH IN THE UNITED STATES ADMITTED USE OF SOME ILLICIT DRUG DURING PREGNANCY (MOST PREVALENT DRUG OF CHOICE WAS COCAINE). THIS EQUATES TO APPROXIMATELY 375,000 INFANTS ANNUALLY (LOS ANGELES TIMES, 10/2/89). IN CALIFORNIA, PERCENTAGES RANGE FROM 22% AT UC DAVIS HOSPITAL, TO 15% AT MARTIN LUTHER KING HOSPITAL, TO 10% AT HARBOR-UCLA HOSPITAL.

THESE FIGURES ARE LOW ESTIMATES AT BEST, SINCE THERE IS CURRENTLY NO SYSTEMATIC OR MANDATED REPORTING SYSTEM IN PLACE WHICH CAPTURES THE DATA REGARDING THE NUMBER OF DRUG EXPOSED INFANTS. ROUTINE TESTING IS NOT CONDUCTED AT BIRTH, NOR IS THERE ANY STANDARDIZED PROTOCOL IN ALL HOSPITALS REGARDING CONDITIONS FOR A TOXICOLOGY SCREEN AT BIRTH. WHAT WE ARE SEEING IS PROBABLY ONLY THE TIP OF THE ICEBERG.

FROM 1981-1987, LOS ANGELES COUNTY REGIONAL CENTER CASELOADS HAVE INCREASED 83.2%. CALIFORNIA CHILDREN'S SERVICES CASELOADS HAVE RAISED BY 56.3%. ALTHOUGH PART OF THIS RAISE IS DUE TO AN INCREASE IN THE NUMBERS OF INFANTS AGE 0-4 (33.5%), MUCH OF THIS RISE IS RELATED TO INCREASES IN TECHNOLOGY ENABLING MORE LOW BIRTH WEIGHT INFANTS TO SURVIVE AND THE DRAMATIC ELEVATION IN THE NUMBERS OF DRUG EXPOSED INFANTS ACCESSING THESE SYSTEMS FOR SERVICES.

CHILD WELFARE SYSTEMS HAVE NO CONSISTENT DATA AVAILABLE. IN CALIFORNIA, SACRAMENTO COUNTY REPORTED AN AVERAGE OF 115 CASES OF DRUG EXPOSED INFANTS PER MONTH IN 1988. THE LOS ANGELES COUNTY FIGURE REFLECTS A 1100% INCREASE FROM 1981-1987. ACTUAL CASE COUNT IN 1989 WAS 2784.

DIFFERENTIAL IMPACT ON HIGH RISK GROUPS

AS WITH SUBSTANCE ABUSE, PERINATAL ADDICTION CUTS ACROSS ALL RACIAL AND SOCIOECONOMIC LINES. HOWEVER, SINCE NO STANDARD OR MANDATED PROTOCOL IS IN PLACE, IT IS THE HOSPITAL'S DECISION ON HOW TO ADDRESS THE ISSUE. CURRENTLY, THE MAJORITY OF HOSPITALS WHO HAVE PROTOCOLS AND ROUTINELY TEST ARE PUBLIC HOSPITALS. THIS RESULTS IN A DISPROPORTIONATE NUMBER OF INFANTS BEING IDENTIFIED WHO ARE POOR AND MINORITIES. IN LOS ANGELES COUNTY, 70% OF ALL DRUG EXPOSED INFANTS REPORTED ARE BLACK.

IN ADDITION, IN RESEARCH CONDUCTED ON PREGNANT ADDICTS, THE OVERWHELMING FINDING IS THAT WOMEN AT HIGH RISK FOR SUBSTANCE ABUSE HAVE HISTORIES OF ABUSE, BATTERING, RAPE, INCEST AND FAMILY HISTORIES OF CHEMICAL DEPENDENCY. CURRENTLY, DRUG EXPOSED INFANTS ARE NOT INCLUDED IN THE LIST OF MANDATED CASES FOR REPORTING AS CHILD ABUSE AND NEGLECT IN THE STATE OF CALIFORNIA. IN FACT, THERE IS NO STATE MANDATED SYSTEM OR PROTOCOL FOR IDENTIFICATION

AND/OR REFERRAL OF DRUG EXPOSED INFANTS AT BIRTH OR DURING THE PREGNANCY.

THROUGHOUT CALIFORNIA, THIS HAS RESULTED IN A COUNTY BY COUNTY DETERMINATION OF HOW TO ADDRESS THE ISSUE OF PERINATAL SUBSTANCE ABUSE. IN LOS ANGELES COUNTY, PREGNANT ADDICTS HAVE RESORTED TO FOREGOING PRENATAL CARE AND "HOSPITAL SHOPPING" TO AVOID THE PUNITIVE IMPACT OF DELIVERING A DRUG EXPOSED INFANT. THUS BOTH MOTHER AND INFANT RECEIVE NO BENEFIT FROM TREATMENT SERVICES, WHICH WOULD IMPROVE THE PREGNANCY, THE BIRTH OUTCOME AND THE REHABILITATION OF THE MOTHER.

RESPONSE BY SOCIAL SERVICE SYSTEMS

INITIAL RESPONSES BY CHILD PROTECTIVE SERVICES WERE TO REMOVE THE CHILD AND PLACE THEM IN FOSTER CARE. HOWEVER, THE CURRENT EPIDEMIC HAS FORCED CHILD WELFARE SERVICES TO ALTER THEIR INITIAL RESPONSE. THIS ALTERATION IS DUE, PRIMARILY, TO THE LACK OF AVAILABLE FOSTER HOMES FOR THESE INFANTS. AN INCREASED NUMBER OF INFANTS ARE NOW REMAINING WITH THEIR MOTHERS OR WITH EXTENDED FAMILIES. THIS CHANGE IN PRACTICE HAS NOT BEEN SUPPORTED BY SERVICES AVAILABLE TO MOTHER AND CHILD TO MAINTAIN AND/OR REUNIFY THE FAMILY.

OTHER SYSTEMS INVOLVED IN THE PROVISION OF SERVICES NEEDED BY THIS POPULATION (REGIONAL CENTERS, MATERNAL AND CHILD HEALTH, AND DRUG TREATMENT PROGRAMS), HAVE RESPONDED BY ATTEMPTING TO INCREASE SERVICES. THIS ATTEMPT HAS NOT BEEN REALIZED DUE TO LIMITED FUNDING AND NO CLEAR GOAL OR FOCUS THAT IS ACCEPTED UNIVERSALLY, LEAVING SERVICES FRAGMENTED.

COSTS OF PERINATAL SUBSTANCE ABUSE

THE COST OF PERINATAL SUBSTANCE ABUSE HAS PROBABLY DONE MORE TO BRING THIS TO THE PUBLIC'S AND POLITICAL SYSTEM'S ATTENTION THAN ANY OTHER FACTOR. IN CALIFORNIA, HOSPITAL EXPENSES ARE ESTIMATED AT $178 MILLION ANNUALLY FOR THE ADDITIONAL COSTS RELATED TO DRUG EXPOSED INFANTS. THE MAJORITY OF THIS FUNDING IS COMING FROM THE MEDI-CAL, MEDICAID AND CALIFORNIA CHILDREN'S SERVICES PROGRAMS. THE COSTS CONTINUE TO RISE THROUGHOUT THE CHILD'S LIFE AS SERVICES ARE REQUIRED FROM OTHER SOCIAL SERVICE PROVIDERS. DEVELOPMENTAL PROGRAMS ESTIMATE AN INCREASE OF $70,000 ANNUALLY FOR A DRUG EXPOSED INFANT. CHILD PROTECTIVE SERVICES ESTIMATES AN ANNUAL COST OF $24,000. THE EDUCATIONAL SYSTEM ESTIMATES AN ADDITIONAL $5,900 ANNUALLY FOR SPECIAL PROGRAMS AND SERVICES FOR EACH CHILD. CALIFORNIA LT. GOVERNOR LEO MCCARTHY, IN A PERINATAL SUBSTANCE ABUSE INITIATIVE INTRODUCED IN 1989, ESTIMATES $400,000 IS SPENT ANNUALLY ON A DRUG EXPOSED INFANT, FROM BIRTH THROUGH THE AGE OF EIGHTEEN.

IF NON-PUNITIVE PREVENTIVE AND EARLY INTERVENTION PROGRAMS WERE PROVIDED . . . "THE SAVINGS IN HOSPITAL CARE ALONE WOULD PAY FOR BOTH DRUG TREATMENT AND PRENATAL CARE FOR THIS POPULATION" (BEAN IN SEYMOUR, P.13).

CONSEQUENCES OF PERINATAL SUBSTANCE ABUSE

THE CONSEQUENCES OF PERINATAL SUBSTANCE ABUSE ON THE INFANT, MOTHER AND FAMILY ARE OVERWHELMING.

AS INDICATED PREVIOUSLY, THE INFANT EXPERIENCES BOTH SHORT AND LONG-TERM MEDICAL, BEHAVIORAL AND DEVELOPMENTAL PROBLEMS THAT CAN LAST THROUGHOUT THEIR LIVES. IF RETURNED TO THEIR DRUG ABUSING MOTHER, THEY ARE AT HIGH RISK FOR CHILD ABUSE AND NEGLECT IF ADEQUATE SUPPORT AND SERVICES ARE NOT PROVIDED. IF PLACED IN FOSTER CARE, THEY ARE OFTEN SUBJECT TO A MULTITUDE OF FOSTER HOME PLACEMENTS, PARTLY DUE TO THE INTENSITY OF THEIR NEEDS: "MULTIPLE

FOSTER PLACEMENTS, THEREFORE, RESULT WITH DEVASTATING EFFECTS ON THE DEVELOPMENT OF THESE CHILDREN" (BEAN IN SEYMOUR, P.14). AS STUDIES HAVE INDICATED, THESE CHILDREN APPEAR UNABLE TO DEVELOP ATTACHMENTS AND RELATE TO THE WORLD. THE DRUGS SEEM TO " . .INTERFERE . . .WITH THE CENTRAL CORE OF WHAT IT IS TO BE HUMAN" (NIDA, NEW YORK TIMES 9/17/89) AND INTERRUPT THE PROCESS OF GROWTH THROUGH NORMAL DEVELOPMENTAL LIFE TASKS. THIS CAN RESULT IN CHILDREN WITH VERY POOR SELF-ESTEEM, LIMITED ABILITY TO DEVELOP APPROPRIATE SOCIAL RELATIONSHIPS, IN ADDITION TO BEING AT HIGH RISK FOR SUBSTANCE ABUSE AS THEY GROW OLDER. THIS DOES NOT EVEN TAKE INTO ACCOUNT THE LOSS OF "POTENTIAL TALENTS, SKILLS AND ABILITIES OF THESE CHILDREN" (HOWARD IN SEYMOUR, P. 61).

FOR THE MOTHER, THE CONSEQUENCES OF PERINATAL DRUG USE ARE JUST AS GREAT. POOR NUTRITION AND LACK OF PRENATAL CARE PUT HER HEALTH AT RISK ALSO. IF HER INFANT IS REMOVED FROM HER AT BIRTH, IT CAN CREATE DEVASTATING EFFECTS. PREGNANCY AND MOTHERHOOD ARE EVIDENCED AS THE STRONGEST MOTIVATING FORCES FOR A WOMAN TO REMAIN DRUG FREE. THE ABILITY TO DEVELOP BONDING WITH HER CHILD DURING THIS PERIOD IS CRITICAL TO A SUBSTANCE ABUSING MOTHER'S RECOVERY. IF THAT MOMENT IS LOST, THE MOTHER IS OFTEN LOST ALSO, BACK TO THE DRUG WORLD WITH LITTLE HOPE FOR REUNIFICATION. WHAT IS PERHAPS EVEN MORE CRITICAL IS THAT THE MOTHER WILL REPLACE THE FIRST INFANT WITH ANOTHER PREGNANCY AND, CONSEQUENTLY, ANOTHER DRUG EXPOSED INFANT.

EXISTING RESOURCES

IN LOS ANGELES COUNTY, THERE ARE CURRENTLY 17 EXISTING PROGRAMS CONTRACTED WITH THE DEPARTMENT'S DRUG ABUSE PROGRAM OFFICE TO PROVIDE SERVICES SPECIFICALLY FOR PREGNANT AND PARENTING WOMEN WHO ABUSE DRUGS.

THERE ARE THREE EARLY INTERVENTION PROGRAMS LOCATED AT THREE COUNTY MEDICAL CENTERS: COUNTY USC, MARTIN LUTHER KING AND HARBOR-UCLA. THESE PROGRAMS TARGET PREGNANT AND POSTPARTUM WOMEN WHO ARE IDENTIFIED AS DRUG USERS/ABUSERS. SERVICES INCLUDE: COUNSELING; NUTRITION AND HEALTH EDUCATION; AIDS EDUCATION; SUPPORT GROUPS; WOMEN SPECIFIC GROUPS; PARENTING EDUCATION AND LIFE SKILL DEVELOPMENT. CLIENTS ARE REFERRED TO LOCAL DRUG TREATMENT PROGRAMS WHEN APPROPRIATE. MEDICAL SERVICES (PERINATAL AND PEDIATRIC CARE) ARE AVAILABLE ON SITE. DURING FISCAL YEAR 1988-89, THESE PROGRAMS PROVIDED SERVICES TO 452 WOMEN AND THEIR CHILDREN.

FIVE METHADONE MAINTENANCE PROGRAMS PROVIDE A SPECIAL SERVICE COMPONENT TARGETING PREGNANT AND POSTPARTUM IVDU'S. THE COMPONENT IS ADMINISTERED BY A PERINATAL NURSE SPECIALIST TRAINED IN PUBLIC HEALTH AND PERINATAL DRUG ABUSE. SERVICES INCLUDE: INDIVIDUAL AND GROUP COUNSELING; WOMEN SPECIFIC GROUPS; MEDICAL CARE; CASE MANAGEMENT; NUTRITION AND HEALTH EDUCATION; AIDS EDUCATION; AND PARENTING EDUCATION. SERVICES ARE CONTINUED UNTIL THE CHILD HAS REACHED THREE YEARS OF AGE. IN FISCAL YEAR 1988-89, THE FIVE NURSE SPECIALISTS PROVIDED SERVICES FOR 195 WOMEN AND THEIR CHILDREN.

FOUR OUTPATIENT DRUG TREATMENT PROGRAMS ARE AVAILABLE FOR WOMEN, INCLUDING PREGNANT AND PARENTING WOMEN IN THE COUNTY. SERVICES INCLUDE: INDIVIDUAL, FAMILY AND GROUP COUNSELING; REFERRALS TO VOCATIONAL, EDUCATIONAL, MEDICAL AND LEGAL SERVICES; AND AIDS EDUCATION. IN FISCAL YEAR 1989-90, THEY HAVE A TOTAL STATIC TREATMENT CAPACITY OF 173. IN FISCAL YEAR 1988-89, THEY PROVIDED SERVICES TO 479 WOMEN AND THEIR CHILDREN.

THERE ARE FOUR RESIDENTIAL DRUG PROGRAMS THAT ARE AVAILABLE ON A COUNTYWIDE BASIS FOR PREGNANT WOMEN AND WOMEN WITH THEIR CHILDREN. SERVICES INCLUDE: ROOM AND BOARD; INDIVIDUAL, GROUP AND FAMILY COUNSELING; WOMEN-SPECIFIC GROUPS; AIDS EDUCATION; PARENTING EDUCATION; REFERRALS FOR VOCATIONAL, EDUCATION, MEDICAL

AND LEGAL SERVICES; AND LIFE SKILLS DEVELOPMENT. IN FISCAL YEAR 1989-90, THEY HAVE A COMBINED STATIC TREATMENT CAPACITY OF 105. IN FISCAL YEAR 1988-89, THEY PROVIDED SERVICES TO 315 WOMEN AND THEIR CHILDREN.

IN SEPTEMBER, 1989, WE IMPLEMENTED A COLLABORATIVE EARLY INTERVENTION PROGRAM WITH THE LOS ANGELES UNIFIED SCHOOL DISTRICT AND AVALON CARVER COMMUNITY CENTER TO PROVIDE COUNSELING AND CHILD DEVELOPMENT SERVICES TO FAMILIES WITH INFANTS 0-3 EXPERIENCING PROBLEMS DUE TO DRUG USE/ABUSE. ADDITIONALLY, LOS ANGELES COUNTY HAS RECEIVED APPROXIMATELY $2.9 MILLION FOR PILOT PERINATAL PROJECTS IN TWO SITES, IN THE SOUTH CENTRAL AND HARBOR AREAS. THE DEPARTMENT OF HEALTH SERVICE ALCOHOL AND DRUG PROGRAM ADMINISTRATION HAS RECEIVED A TOTAL ALLOCATION OF APPROXIMATELY $1.9 MILLION FROM THESE FUNDS TO DEVELOP AND IMPLEMENT SERVICES FOR PERINATAL DRUG AND ALCOHOL ABUSERS IN COLLABORATION WITH THE DEPARTMENT OF CHILDREN'S SERVICES, LOCAL MATERNAL AND CHILD HEALTH PROVIDERS AND THE LOS ANGELES COUNTY PERINATAL SUBSTANCE ABUSE COUNCIL.

UNFORTUNATELY, THESE RESOURCES PROVIDE SERVICES TO ONLY A FRACTION OF WOMEN AND INFANTS IN NEED.

IMPLICATIONS FOR SOCIAL WELFARE PLANNING

WE RECOMMEND THE FOLLOWING:
THE IMPLICATIONS FOR SOCIAL WELFARE PLANNING APPEAR EVIDENT:

1) DEFINE THE GOALS AROUND MAINTENANCE OF THE FAMILY SO THAT FRAGMENTED APPROACHES AND SERVICES BEING OFFERED CAN BE JOINED.
2) IMPLEMENT POLICIES AND PROGRAMS TO SERVE THIS COMMON GOAL.
3) MODIFY METHODS OF FUNDING AND REALIGN CURRENT SERVICE FOCUS TO ENCOMPASS THE FAMILY AS A UNIT.
4) DEVELOP A COMPREHENSIVE APPROACH THAT ADDRESSES OUTREACH, PREVENTION, EARLY INTERVENTION AND TREATMENT TO CONFRONT THE MULTIPLE CAUSES OF DRUG ABUSE, INCLUSIVE OF BIOLOGICAL, SOCIAL AND ECONOMIC FACTORS THAT CONTRIBUTE TO THE PERPETRATION OF DRUG USE AND ABUSE IN OUR SOCIETY.

SUMMARY

IN SUMMARY, THE COSTS OF PERINATAL DRUG ABUSE TO SOCIETY - ECONOMIC, SOCIAL AND HUMAN - ARE TOO DEVASTATING TO EVEN BEGIN TO CALCULATE. THE DRAIN ON THE EDUCATIONAL, MEDICAL AND SOCIAL SERVICE SYSTEMS ARE JUST BEGINNING TO BE FELT AND WILL CONTINUE TO ESCALATE.

MANY HAVE STATED THAT WE WILL LOSE A GENERATION TO DRUG USE. PERHAPS, MORE SIGNIFICANT IS THAT WE ARE LOSING FAMILIES. UNTIL WE CONSIDER THIS AND BEGIN TO PROVIDE COMPREHENSIVE SERVICES TO "RESTORE" THE FAMILY, THE LOSS TO SOCIETY WILL CONTINUE AT A MAGNITUDE WE HAVE NOT FELT BEFORE.

THANK YOU FOR THIS OPPORTUNITY TO PROVIDE TESTIMONY TO THE COMMITTEE.

ROBERT C. GATES
DIRECTOR

NATIONAL
BLACK
CHILD
DEVELOPMENT
INSTITUTE, INC.

EXHIBIT FOR THE RECORD IN CONJUNCTION WITH HEARINGS HELD BY

SUBCOMMITTEE ON HUMAN RESOURCES OF THE
COMMITTEE ON WAYS AND MEANS OF THE
U.S. HOUSE OF REPRESENTATIVES
APRIL 3 AND 4, 1990

EXHIBIT PREPARED BY THE NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE
SELECTED EXCERPTS FROM WHO CARES WHEN PARENTS CAN'T? A STUDY OF BLACK CHILDREN IN FOSTER CARE - Clarice Walker, Principal Investigator, Evelyn K. Moore, Executive Director

Distinguished Committee Members and Guests:

For nineteen years, the National Black Child Development Institute (NBCDI) and its local affiliates have been advocates for children and specifically, black children and their families. A particular focus of our work has been children in their own homes in need of services and children without homes in need of families and services. NBCDI is engaged in the struggle to reform and strengthen a child welfare system that has historically ill served our children and their families. In these and other efforts, a major focus of our concern has been foster care and the continuing high numbers of black children represented in that system.

The National Black Child Development Institute is pleased to inform you of a two- and one-half-year project conducted by our organization on black children in foster care. We have selected excerpts from the report of the study which include a description of the project, a summary of key findings, a detailed description of specific findings that address the focus of this hearing, and recommendations based on the findings.

This exploratory study of 1,003 children was conducted in five cities located in different geographic areas of the United States-Detroit, Michigan; Houston, Texas; Miami, Florida;, New York City, New York and Seattle, Washington. The intent and the design of the research was twofold: 1) to provide an in depth profile of black children in the foster care system which would include a profile of the families of these chidden, and the social context of their lives before entering foster care and during foster care; and 2) to engage the citizens of local communities where these children live as volunteer researchers to collect the data and as a result of this experience become more effective advocates for children and better able to solve community problems.

Some of the variables which we examined were: 1) reasons for placement; 2) what services the agency provided on behalf of the child and family; 3) how relatives were used during this intervention; and 4) outcomes in terms of discharges.

Community researchers were trained to compile data utilizing a standard form called the Case Record Review Form. These data were collected from case records located in the public child welfare agency. The goal of the case record review was to document the totality of the circumstances of each child which had been hidden

in the courts and the child welfare agency. Due to the confidential nature of the information in case records, procedures with each agency system were developed to ensure that appropriate safeguards were employed.

Selected Major Findings

- In 1986, younger children were entering foster care at a disproportionate rate compared to other age groups. The proportion of children five years old or younger at placement was 49 percent.

- In 62 percent of the homes of the children before placement, the mother was the head of the household. Generally these parents were not teens when the study child was placed in care. The mean age of the mothers of the study population at the time of placement was 29 years; the mean age of the fathers at placement, when the information was available, was 34 years. AFDC was the primary source of income for 65 percent of the families for which income information was available.

- Inadequate housing was reported as a contributing factor to placement in 30 percent of the total study population. Eight percent of the total study population was homeless before placement. With AFDC as the primary source of income for 65 percent of the families it was discovered that AFDC grants in the study households were well below the amounts needed to meet the rental costs for "decent, safe and sanitary" housing in the study cities. In two of the study cities, Houston and Miami, the amount of the AFDC grant was less than the estimated cost of renting adequate housing. In the other three cities, the AFDC grant would pay the rent but the family would have less than $20.00 per month for all other expenses including food, clothing, child care and transportation. Based on the household income information, it was apparent that a majority of the children in the study population were living in households that could not afford decent housing and also provide for the other basic needs of the family. Inadequate housing was reported as one of the remaining barriers to reunification for 34 percent of the children not discharged by the end of the study period.

- The two most frequent services offered to the parents prior to and during placement were casework services and parenting education, while transportation, housing assistance and financial assistance were offered to fewer than 15 percent of the total population.

- The primary reason for placement was neglect, including abandonment for 49 percent of the total population, but Houston had more cases with abuse as the primary reason and Seattle had more voluntary placements as the primary reason. After neglect and abuse, drug abuse was the most frequently reported family factor contributing to placement. While drug abuse of the parents was reported as contributing to placement in 36 percent of the total study population, referrals for drug rehabilitation were only offered to parents before placement in 16 percent of the cases. Drug abuse of the parents was reported as one of the remaining barriers to reunification for 30 percent of the children not discharged

by the end of the study period.

Because this hearing focuses on children of drug abusing parents the segment of the study that examines drug abuse and foster care placements is provided in more detail.

Drugs have taken their toll on women and children.

News reports focus almost entirely upon the ill effects that the crack cocaine epidemic is having on young, black males, by citing drug-related violence statistics on a daily basis. Researchers report that males are more likely to become substance abusers than females. Much addiction research and treatment models have focused on male drug abusers. However, women and their children are also suffering dire consequences from illegal drug use. One of the most commonly reported impacts of drugs is drug exposure in the fetus and neonate. The Select Committee on Children, Youth and Families (1989) released the results of a survey of hospitals in large metropolitan areas. Of the 18 hospitals surveyed, there was an increase in the incidence of substance abuse during pregnancy and the number of drug-exposed births since 1985. In New York City, the number of drug-exposed infants increased 12 percent from 1985 to 1988. In Detroit, the number of narcotics-exposed infants increased from 9.1 percent of births in 1985 to 10.4 percent in 1987. In Houston, the number of drug-exposed infants increased form 1.73 per hundred infants admitted to the neonatal intensive clinic to 4.9 per hundred between July 1986-June 1987 and July 1987-June 1988. Most of the hospitals reported that since 1980, crack cocaine has become the drug of choice for these women.

Women who abuse drugs shortly before or during pregnancy are threatening their baby's welfare, although they may not be aware of this. In fact, in some states the birth of a drug dependent baby can in itself be grounds for child abuse. According to Chasnoff (1988), the fetus shows clinical signs of withdrawal 60-90 percent of the time when the mother's drug is removed from it, either during pregnancy or at birth. Resulting problems include irritability, restlessness, poor feeding, crying and impaired neurobehavioral functioning. Cocaine withdrawal may cause seizures in some infants. The cocaine babies also lose excessive weight and have trouble regaining it. Chasnoff further reports that infants born to drug abusing mothers have an increased chance of perinatal morbidity and mortality. The Office of Substance Abuse Prevention (1989) claimed children born to cocaine abusers during pregnancy were said to experience a higher rate of kidney and breathing disorders, a higher risk of sudden infant death syndrome, and increased risk of visual and coordination problems and of developmental retardation. Researchers (Weston, Ivins, Zuckerman, Jones, and Lopez, 1989) warn that the effects of drug exposure to the unborn are not certain at birth. They emphasize that different types of drugs can have different effects on the child as do doses and periods of exposure, and that the full effects may not be known until specific developmental stages are reached in childhood or adolescence.

The relationship of maternal drug use to increasing numbers of newborn infants entering the child welfare system is substantiated by study findings and reports around the country. Chasnoff (1988) reported that Los Angeles in 1985 had 9 percent of its total child abuse reports due to neonatal withdrawal during

pregnancy; in the first half of 1986, the rate had increased to 9.4 percent. In some cases, as many as 60 percent of drug exposed babies are placed into foster care (Halfon, 1989).

Boarder babies also pose a serious dilemma for hospitals and child welfare systems. Reports from various cities also indicate that boarder babies are a serious problem, both for the infants and the hospitals. Abandoned babies who are in need of homes, not medical care, are being cared for in hospitals at a cost of $600 or more per day. From the study findings, it was demonstrated that in New York, where the number of hospital boarder babies was straining the child welfare system in 1986 because of its magnitude, 24 percent of children who had child-related contributing factors to placement were hospital boarder babies. (See Table 5 - Placement.)

The study makes clear that the mothers studied who abused drugs had difficulty taking care of their children, sometimes neglecting them severely - physically, educationally and medically. Although not specifically studied in our data, a child's emotional needs may also be seriously threatened by a mother's drug dependency. In NBCDI's roundtable discussion, agency representatives reported that some long-term, chronic drug users also physically abuse their children.

Families with drug abusing mothers and older children at home are described as being unpredictable (Beckwith, Rodning, and Kropenske, 1989). The mother may have a primary commitment to drugs and not to her children. The needs of children are often secondary to the drive for drug use, which leads to the impairment of the mother's thoughts, perception, and memory. Research on heroin-abusing mothers demonstrated that these women often had their children living with a relative, in foster care, or adopted (Kumpfer, 1987). Statistics have shown that drug abuse and dependence was the second most frequently reported mental health disorder for women aged 18 to 24 (National Institute of Mental Health, 1984).

The children of substance abusing mothers were described by Kumpfer as being overrepresented in social service programs, as summarized from her review of the literature. Children of drug abusing mothers were found in disproportionate numbers in: intensive care services for birth defects and fetal alcohol syndrome; children's attention deficit disorder (ADD) or hyperactivity treatment programs; classes for the emotionally disturbed or handicapped in public schools; child abuse counseling programs; adolescent psychiatric inpatient programs and child psychiatric outpatient programs; hospital treatment for somatic complaints; teenage mother pregnancy programs; juvenile court case loads; and adolescent and adult substance abuse treatment programs. It is clear that children of substance abusers are at special risk of emotional, educational, social, behavioral, and medical problems. Intensive treatment in multiple areas, therefore, may be necessary.

Effective treatment programs for drug abusing mothers and their children are crucial.

From a first look at treatment programs for drug abusing mothers, there appears to be a sorely inadequate supply of drug rehabilitation programs to meet the current demand. Also there are unrealistic criteria for treatment that ultimately deny treatment to women like those in our study population. Women who are pregnant, still taking drugs, with child care responsibilities, or unable to pay for residential treatment may be refused enrollment. Most likely, a mother wishing to enroll in a program is also faced with a long waiting list. In the previously mentioned Congressional survey, eight out of 18 hospitals surveyed, including in Miami, reported they had no place to send pregnant women for drug treatment.

Also many drug programs that are available may not be designed specifically for the now common crack cocaine user. The highly addictive nature of crack and the intense euphoria of the drug are unlike other drugs normally treated in rehabilitation programs. Many programs are still geared to the treatment of heroin addiction. C. Shuster of NIDA (1988) remarked, "Treatment programs across the country are utilizing a variety of behavioral and pharmacologic approaches for the treatment of cocaine addiction, but there is little hard evidence demonstrating their efficacy." More research is needed on crack cocaine addiction. Because many of the more successful treatment programs for drug abusers involve residential treatment, their expense presents a further barrier to the study population. Residential programs require insurance coverage or personal ability to pay. Unless publically funded, these programs are out of financial reach for the study population.

Rehabilitation efforts with drug abusing mothers through child welfare systems are thwarted in a variety of ways. Outreach techniques are required, yet there are increasing concerns by social workers and medical personnel about safety. Some of the problems workers have in working with drug abusing mothers are that they are frequently unstable, move often, lack telephones, and fail to keep appointments (Beckwith, Rodning, and Kropenske, 1989).

INNOVATIVE TREATMENT APPROACHES

Although more research is needed to determine effective and efficient treatment program strategies, and though more affordable and available treatment programs are necessary, there are some exemplary treatment models to replicate and expand. Three of these innovative programs are described for their relevance to families at risk of foster care:

A Preventive Program for Pregnant Mothers. The first program entitled PAAM anticipates the stresses of parenthood on a drug abusing mother, particularly when the infant will undergo withdrawal. This PAAM program is a component of the Center for Comprehensive Health Practice of New York Medical College (Lief, 1987). It is designed to prevent child abuse and/or neglect by providing support to the mother through pregnancy and delivery. Typically when drug withdrawing infants are kept in the hospital after birth to attend to their medical needs, mother-infant bonding is adversely affected. The program offers the mother obstetrical care, and pediatric, psychological and family services, while educating her about the special needs of her child. As a result of the program the mothers were said to have an increased and sorely needed sense of self-confidence in their mothering abilities. This in turn led to their competency in parenting.

Collaboration Between Child Welfare and Drug Treatment Services. A second model deals with treatment for a mother who is drug dependent and has abused or neglected her child or children. Child welfare systems do not ordinarily have the capacity to directly deal with drug problems, nor do drug treatment programs have the capacity to deal with child abuse and neglect problems. Therefore, a collaborative effort on the part of the child welfare system and the drug treatment program is needed. The advantages and problems of such a collaboration were identified by Reed, Laird, Hartman, and Harding (1987). Drug treatment programs are often sought by women who are concerned about their children. Having children and parenting issues both as part of drug treatment, though unusual, has been shown to help sustain

mothers in treatment. It is important that drug abuse and child neglect and/or abuse be addressed together in treatment.

A Residential Drug Treatment Program for Both Women and Children. A final innovative drug treatment program was described by Pearlman, West and Dalton (1987). Family House in Pennsylvania is a good example of a child and mother directed drug treatment program. Most residential drug treatment programs do not allow children. In Family House, the children live with the mother. Mother learns the techniques of parenting while she is learning to stay off drugs. Staff are there to support her but not to usurp her parenting role. The children must, at the same time, learn to adjust to their mother's new parenting skills and are encouraged to discuss their problems or complaints with this. Many older children have taken the parental, adult role upon themselves, especially regarding younger siblings, from the time when their mother began using drugs. They too then must learn how to make adjustments when their mothers begin to reassume their parental roles. At the end of this program an evaluation is made on whether or not the mother can return to live with her children in the community.

WHAT THE FUTURE MAY HOLD

Without a decrease in the amount of drug use in the general population and without more available and effective treatment alternatives for maternal drug abusers, the numbers of black children in foster care may increase dramatically in years to come. It was reported by the roundtable representatives from the five cities, that the future is already here. Children in 1988 and 1989 came into care in record numbers due in large part to their mother's drug abuse. Houston, the city reporting the lowest incidence of parental drug use in 1986, can now claim that it is seeing drug problems like never before that are bringing children into care.

RECOMMENDATIONS

Since 1980, with the enactment of Public Law 96-272, child welfare public policy has undergone considerable change. Much of this change has occurred because of the increasing attention that has been focused on the concept of replacing routine foster care with a more comprehensive approach involving "permanency planning" for children. Prior to 1980, children could be placed in foster care (often without a court hearing) if such care was "in their best interest." Most children in foster care were not under court supervision and their status in foster care was not reviewed by the agency or a court on any regular basis.

Despite attempts to reform the system, in far too many cases, foster care does not mean a fresh start for these children, but rather a disruption in lives already disrupted by inadequate housing, poverty, drugs, and absentee parents. Abundant evidence shows that children flourish and thrive in a strong, stable environment. The foster care system is unable to provide such an environment. It destroys existing emotional bonds without replacing them. It provides care that is inappropriate, unstable and inadequate. And the existing problems that led to the need for foster care go unsolved.

1. The state must be responsible for developing and providing a comprehensive system of care for children that is committed

to the preservation of families. To accomplish this goal, states should:

- o establish a permanent legislative body that would monitor, coordinate, and oversee all state systems that provide services to children and their families;
- o require state agencies to develop detailed interagency agreements that would improve interagency collaboration, and assist district offices in providing coordinated services to children and families;
- o improve the capability for and promote the sharing of information about children and families between social service agencies so each agency working with a child or family will have complete and accurate information;
- o develop and establish a set of preventive and reunification services, including "concrete" services, that will be provided to children at risk of placement and children in foster care and their families on a consistent state-wide basis;
- o require the child welfare agencies to make available to the courts a comprehensive listing of the preventive and reunification services provided by the child welfare agency and other social service agencies;
- o promote the establishment of citizen foster care review boards;
- o establish information systems capable of keeping track of the foster care status and living arrangements of the child, services provided to the child and family, and other transactions affecting the child.

2. Child welfare agencies should:

- o establish comprehensive health programs for every child in foster care, ensuring that the provisions of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) are made available to all children;
- o develop, maintain in the foster care record, and provide to the parent or adoptive parent of the child at the time of discharge, the child's health records that contain information about the child's health, treatments received, identifying and contact information about the health care providers, dates of treatment, immunizations data, information about allergies and other health problems or conditions, dental care information, and developmental or mental health information;
- o develop a Health Passport for the child which contains a comprehensive summary of the child's health status, a health history, identifying information, immunization records, developmental needs, and dental care information. The Health Passport should be made available to the child's current foster care provider;
- o ensure that there is no disruption of the education or school attendance of children due to a foster

care placement; children should receive full academic credit for any work completed at an "old" school when transferring to a new school, children should be allowed to continue attendance at the "old" school until the transfer to the new school has been completed, and transfers of the school records between schools or school districts should be required within five working days;

- o obtain a comprehensive educational assessment for every school age child at the time of entry into foster care. Services should be provided that will focus on ameliorating any identified need, and periodic progress reports should be completed and included in the foster care record;

- o reduce the caseloads and paperwork requirements of child welfare workers to increase the time available for the workers to provide direct services to the children and their families;

- o recruit qualified, professional child welfare staff and provide specialized training through continuing education;

- o provide foster parents with training in child development, parent-child interaction, parent education, and special needs of children; and

- o provide supports, such as respite service and child care, to attract potential foster parents from a variety of groups in the community.

3. Relatives should be considered a potential and actual resource to children, and child welfare agencies should:

   - o establish a systematic procedure for making a "diligent search" to locate relatives of children in foster care; and
   - o make available to relatives providing foster care the same payment rate, support services, training, and monitoring that are available to non-relative foster care providers.

4. Drug treatment programs, including residential programs, should be developed which take into account the unique needs of parents with child caring responsibilities.

5. Child welfare agencies should collaborate on an ongoing basis with drug treatment programs to establish a unified set of treatment goals and approaches for parents who are involved in both drug rehabilitation and child welfare services.

6. Waiting lists for drug treatment should be eliminated for pregnant women who are abusing drugs. Each day of drug exposure during pregnancy is an incubator for disaster.

7. Innovative demonstration and research projects that investigate effective prevention and treatment strategies should be given appropriation and funding priority.

8. The federal government should:

   - o restore funding for construction and development of subsidized housing units;

   - o increase or develop rent subsidies to families with children; and

- o develop incentives that will discourage private owners from converting subsidized housing for low-income families to other uses.

9. The states should:

   - o provide incentives, use sanctions, or other state authority to keep housing affordable;
   - o acquire, rehabilitate, construct, or use any power at their disposal to increase the numbers of housing units that are available to low-income families with children; and
   - o use all resources available to prevent homelessness.

10. Volunteers should be recruited to assist the child welfare agency in locating relatives, providing services to children in foster care (such as mentoring or tutoring), assisting with administrative and clerical activities, and assisting with community outreach.

11. The problems in foster care have reached a crisis requiring a national as well as a community response and commitment. NBCDI recommends:

    - o the establishment of a National Commission on children in the child welfare system to identify, deliberate and recommend strategies for action; and
    - o the establishment of local commissions to identify and work on a community agenda on behalf of children in the child welfare system.

Caring for children must become a priority for this country. The social context of their lives must be known - whether they have a family; whether they live in poverty; whether they live in inadequate, overcrowded housing; whether their parents are crack abusers; whether they make up the nameless, faceless masses who inhabit our inner cities in the homeless population; or whether they live in more idyllic settings.

Children are this country's most valuable resource. In order to protect this resource, it is essential that at the very least all children have families, an economic base, decent housing, health services, adequate nutrition, consistent education, and a safe, loving environment. If, after given appropriate supports, parents cannot provide these, we can no longer turn our backs. We must explore alternative living arrangements for children whose home lives do not serve them well.

The National Black Child Development Institute urges the creation of extensive, adequately funded service programs not only for children but for families. The problems identified in this study are not unique only to children placed in foster care. They are problems that threaten to undermine the stability of our society and the possibilities for this nation's future.